HUMAN RIGHTS HANDBOOK

Human Rights of Mental Health Clients
Role and Responsibilities of Human Rights Officers
Role and Responsibilities of Human Rights Committees
How to Train Staff Regarding Human Rights

Department of Mental Health
May 1993, Rev. October 1997

Note to the Reader
Regulatory Changes to Become Effective January 1, 1998

The Department of Mental Health has reorganized, re-written and in a number of places significantly revised its entire set of regulations (other than its ISP regulations which are in the process of being rewritten). The new regulations have been finalized but do not go into effect until January 1, 1998.

This Handbook has been re-written to reflect the revised regulations. Where there are significant differences between the new and old regulations, the text generally reflects this by a note indicating regulatory revisions. Although the scope and detail of the regulatory changes are too extensive to be adequately summarized here, the more important changes impacting on clients' human rights include:

- private hospitals and IRTPs: inpatient standards (including standards regarding human rights officers and clients' rights) apply equally to DMH inpatient facilities, licensed private hospitals and Intensive Residential Treatment Programs (IRTPs) for adolescent clients;
- inpatient rights: new human rights standards protect access to telephone, mail, visitors and legal representation within private and public hospitals, and IRTPs (see part VI of the Handbook);
- informed consent: both inpatient and community regulations include requirements for the first time regarding informed consent (see part V of the Handbook);
- clients with a history of abuse: as part of an inpatient assessment, clients must be assessed for any abuse history and if there is a history of abuse, staff must develop strategies to minimize the use of restraint or seclusion and minimize the potential for re-traumatization if restraint or seclusion is used (see part XI, section E of the Handbook);
- complaint/investigation regs: these regs have been significantly re-written and will apply equally to private hospitals licensed by DMH (see part IX of the Handbook);
- behavior management: the regulations clarify that behavior management may only be used in child/adolescent inpatient facilities and IRTPs, and the regs set standards for use of behavior management in these facilities (see part XI, section J of the Handbook);
- deemed status: regulations allow private hospitals and community programs to obtain DMH licensing through "deemed status" - i.e., accreditation by another entity; the facility or program must submit plans to DMH for compliance with DMH human rights, restraint and seclusion, and investigation of complaints (and, for community programs, the plan must also address management of client funds and medication administration);
- release from restraint/seclusion: clients in restraint or seclusion must be continuously assessed for readiness to be released (see part XI, section G of the Handbook).
- access to own records: clients have the right to access their inpatient records unless would result in "serious harm" (see part X, section A of the Handbook);
- termination of services: standards have been added governing termination of clients from community programs (see part IV, section E of the Handbook);
- searches: the regs provide new standards/procedures for searching client areas in community programs (see part VI, Community standards section E of the Handbook).

INTRODUCTION.

Purpose of handbook: This human rights handbook has been prepared by the Department of Mental Health (DMH) to assist human rights officers, human rights committee members, clients, family members, DMH and vendor employees and other interested persons to understand the human rights and responsibilities of mental health clients. The handbook is also intended to be used to help train community and inpatient staff regarding human rights.

History of this handbook: This handbook's first edition in 1993 was an integration of major portions of three previous handbooks/manuals - a human rights training manual, a handbook for human rights committee members and a handbook for human rights officers serving community programs. The handbook was revised most recently to include regulatory revisions effective January 1, 1998.

A note to trainers: This handbook is organized into separate topic sections so that a trainer may take the materials presented in any section and separately train staff on that topic. Training exercises (hypothetical and questions intended to elicit thoughtful discussion) for most topics are presented in chapter XIX near the end of this handbook.

It is recommended that the trainer present the training exercises for a particular topic before giving the explanation of the client's human rights - it is our experience that audience participation contributes significantly to the teaching process.

When developing a human rights training program for staff, reference should be made to chapter XVIII "Training Standards for Human Rights" of this handbook. The performance standards in chapter XVIII describe the minimum human rights training which DMH has decided that each staff person should receive.

Inpatient and community human rights: This human rights handbook has been prepared for both inpatient and community programs. However, the rights of clients on an inpatient unit may, at times, be different than the rights of community clients, and occasionally the rights will vary depending on whether DMH is operating, funding or licensing the facility. Those sections of the handbook which apply only to a particular setting are indicated in the heading or text.

Children and adolescents: The human rights of children and adolescents are included in this handbook and are discussed separately when they differ from the rights of adults.

Questions? Any questions, suggestions or other comments on this handbook should be directed to the Special Assistant for Human Rights, Department of Mental Health, 25 Staniford Street, Boston, MA 02114, or telephone at (617) 727-5500 extension 420.

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I. WHY HUMAN RIGHTS?

The importance of understanding and implementing human rights is perhaps best explained by viewing the world from the perspective of a client of mental health services. Clients who have their rights respected feel that the mental health system is responding to them as a whole person. They feel respected as thinking, feeling individuals - for example, they are informed of the reasons for treatment decisions, and they participate as partners in their care and treatment. Feeling respected, making decisions and becoming empowered to take responsibility for our own lives are important to all of us, and contribute significantly to the recovery process.

When a client has a guardian (either the parent of a minor or a court-appointed guardian), it is equally important that the guardian fully participate in the process. By respecting the role of a court-appointed guardian or the parent of a minor to be informed and make decisions for the client, the mental health process in turn respects the human rights of the client.

Clients (and their guardians) whose rights are denied are sometimes embittered, perhaps even traumatized, by their experiences in the mental health system. They may feel betrayed by the very system which is intended to care for them and make them better. Take, for example, the following excerpts from a client's statement regarding informed consent:

> "I'm Marilyn[1] and I always wanted to be a teacher. However, due to my voice problem, this could be difficult. I am very upset about that.
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> "About five years ago, for the second time, I lost my voice. The first time I lost it completely - but after three months off the drug Loxitane, and with speech therapy - I regained it totally. This time I haven't been so lucky. I'm told I have tardive dysphonia. How did I get it? From a combination of different neuroleptic medications - Prolixin, Mellaril and Loxitane.
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> "This voice problem may or may not get better. I can only hope. But no doctor ever warned me that the meds I took could do this to me. Now they tell me it is a direct result of neuroleptics. In hospitals, I never thought I had a choice as to whether I wanted to take meds or not. I never received informed consent or had to sign a form saying that I had a agreed to take meds or not. Even after I lost my voice completely due to Loxitane, in hospitalizations after that, I took the drug again - never thinking that I could refuse it or explain what it had done to me....
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> "No doctor ever told me that I could grow hair on my chin from Stelazine, grit my teeth and develop severe mouth movements on Mellaril, develop a thyroid problem and gain 66 lbs. on Lithium, and lose my vocal ability on Loxitane, Prolixin and Mellaril. Even my parents were eventually against my taking drugs but doctors told them my side effects were <u>not</u> side effects (which, in fact, they were) but rather, <u>part of my illness</u>....
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> "Please tell your doctors to inform their patients adequately of side effects of meds they are to take so that more people do not have their lives disrupted as I have had. Give patients a choice - to sign yes or no. Give them informed consent notices.... I would be so much happier today with my life if my voice was better and if I had received informed consent. Living this way has been hellish. I am hopeful that my voice will improve but please let your doctors think of me when they prescribe meds to patients."

Finally, respecting clients' human rights is necessary so that the program and its staff comply with the law and avoid legal liability. Many human rights are reflected in judicial decisions, statutes or regulations which have the force and effect of law.

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[1]The client's name and identifying information were changed to protect the client's privacy.

II. WHAT ARE "HUMAN RIGHTS"?

The term "human rights" is a broad one, having been defined by DMH to mean the values and principles intended to give full respect to the dignity and worth of each individual client.

DMH Policy states that human rights include:

1. freedom from physical, sexual and verbal abuse,
2. humane and adequate care and treatment,
3. a humane and safe living environment; and
4. to the maximum extent possible and consistent with the client's individual needs, preferences and capacities:

    a. self-determination and freedom of choice,
    b. services which are least restrictive of the client's freedom of movement,
    c. the opportunity to undergo normal experiences even though such experience may entail an element of risk, so long as a client's safety or well-being or that of others will not be unreasonably jeopardized,
    d. access to fresh air, exercise and recreational opportunities,
    e. privacy, including clearly defined private living, sleeping and personal care spaces,
    f. the opportunity to engage in activities and styles of living, consistent with the client's individual desires,
    g. the opportunity to move toward and attain a more independent, less restrictive living environment, and
    h. the opportunity for persons from multi-cultural backgrounds or with particular linguistic or physical needs to participate fully in the activities and services of the program, through staff who possess appropriate language skills and cultural understanding and through interpreter services as necessary to make this possible.[2]

Human rights, at its most basic level, is a client being given the same value, the same respect and the same opportunities that we would want for our son or daughter, or sister or brother, or ourself. And, one should assume, until demonstrated otherwise, that a client has the same legal rights as other persons, - e.g., to vote, associate with others, etc.

Human rights also include a client's legal rights - e.g., those rights specified by statute, regulation or case law. Many human rights are articulated in DMH regulations - e.g., 104 CMR[3] 27.13 which describes the human rights of clients in inpatient facilities and IRTPs, and 104 CMR 28.03 which describes the rights of clients in community programs.

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[2]DMH Human Rights Policy # 95-4. The term "human rights" is defined at pages 2 and 3 of the policy. This policy may be a helpful resource to human rights officers and human rights committee members, and many of the policy's principles are reflected in this handbook.

[3]The initials "CMR" refer to the Code of Massachusetts Regulations - in this case, the DMH regulations. Regulations are promulgated by the Department under the authority of state statute. So long as the regulation is consistent with the statute, the regulation has the force and effect of law. Department policies do not have the same legal effect as regulations but nevertheless are binding on all Department employees and may be enforced through contract with DMH vendors.

III. DIGNITY AND RESPECT.

A. Dignity and respect.

There is perhaps nothing more important to understanding human rights than an appreciation of dignity and respect.

Each of us wants to be valued and respected as a thinking, feeling individual person. We want to be taken seriously, we want to be listened to and participate in decisions that effect us, and we want to take responsibility for, to the extent possible, not only the major events in our lives but also the more routine events - e.g., what we wear, what we eat for breakfast, who our friends are and how to spend our leisure time.

Yet through institutional/program rules, convenience of staff, over-dependence on control, lack of time or patience or a general sense that the caregivers know best, clients are sometimes told what to do rather than allowed to participate in decision-making and take responsibility for their actions. **The caregiver may see the client primarily as an illness which must be treated, rather than someone to be understood and related to as an equal human being who happens to need help with an illness.** But, seeing the client first as a person is critical to giving the client dignity and respect.

As is explained by DMH policy, clients "have the right to receive services . . . which respect and foster [their] dignity, autonomy, positive self-regard, personal integrity, values and beliefs . . . ." DMH Patient Rights and Responsibilities Policy # 95-5R (at part III B 2, page 3).

B. The "dignity of risk".

The principle of taking control of our lives, even when it may involve some risk of harm, is sometimes referred to as **the dignity of risk. Most of us owe a large portion of our personal growth to the process of trial and error.** We try and sometimes we fail. The failure becomes a learning experience and subsequent attempts are bound to meet with a higher level of success.

This principle of learning is at the heart of the mental health service system and the recovery process. **We attempt to foster as much independence as possible and to instill a proportionate sense of responsibility.** We must be willing to allow clients to take the social and personal chances that will facilitate long-term growth toward independent living. These principles apply equally in inpatient and community settings.

At times, however, it may be necessary to limit a client's options - e.g., when there is a significant risk of imminent, serious harm, or when the age of the client makes it inappropriate for her to take on certain responsibilities. But, the long-range goal is always to expand the client's options, abilities and sense of self-worth, and this can only happen if clients are allowed the "dignity of risk" - that is, the opportunity to make one's own decisions, take one's own actions and take control of one's life in pursuit of one's own goals.

A further discussion of these principles is included in an article "The Customer is Always Right", found in chapter XVII of this handbook.

IV. TREATMENT PLANNING AND TERMINATION OF SERVICES.

A. Participation in treatment planning.

The mental health services to be provided a client must be reflected in the client's treatment plan, which must be individualized to address the particular needs of the client.[4] **Clients and their guardians[5] have the right to participate as fully as possible in the development and modification of their treatment plan, including the Individual Service Plan (ISP).**[6] This includes being invited to and attending treatment team meetings as an active participant in treatment-planning decisions.

A client with a guardian has the same right to participate in the development of a treatment plan as any other client, even though it will be the guardian (rather than the client) who has the right to accept or reject the plan, as described below. But, because of the age of a child/adolescent or because of a lack of capacity, a client who has a guardian may not be able to participate as actively or as fully as other clients.

B. Addressing behavior problems within treatment planning.

Wherever possible, behavior problems and other treatment issues should be addressed in the plan. Staff may not implement their own solutions outside of this process. For example, a client with a compulsive eating disorder must have a treatment plan that clearly instructs staff in all of his programs how to monitor diet and prevent overeating. Reasonable restrictions on access to food may be implemented and enforced only as part of a treatment plan accepted by the client or guardian.

Where the client's behavior is causing a problem in a community program, staff must make every reasonable effort to address the situation in order to allow the client to continue in the program. Those efforts include modification of the program specific treatment plan in an attempt to address the problem behaviors. No client may be asked to leave a program if an appropriate alternative can substantially resolve the problem.[7]

C. Accepting/rejecting the treatment plan.

Adult clients who are not under a general guardianship (or a guardianship with general responsibility to make treatment decisions) **have the right to reject and appeal part or all of**

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[4] 104 CMR 16.07(1) and (2). 104 CMR 16 (the DMH Individual Service Planning regulations) are in the process of being revised. This Handbook does not reflect the revisions to these regulations.

[5] A guardian includes a court-appointed guardian of an adult and the parent of a client under the age of 18 years (unless the rights of the parent have been limited by a court or voluntary agreement). See the discussion of guardians in part VIII of this handbook.

[6] 104 CMR 16.05(1)(c), 16.07(1)(g). See also DMH Patient Rights and Responsibilities Policy # 95-5R, part IIIB at page 3.

[7] 104 CMR 28.12(4)(b).

the contents of any treatment plan.[8] The client or guardian may also request modification of a treatment plan or services.[9]

D. Appealing the plan.

A timely-filed appeal delays implementation of a treatment plan, including any significant modification or termination of services. For example, an appeal of a proposed termination of services will delay the termination at least through the appeal process.[10]

However, in an emergency or when necessary to comply with state contracting requirements, a treatment plan may be implemented (and services modified or terminated) even though the client or legal guardian has appealed the plan.[11] An emergency would exist, for example, if a delay in transfer would result in personal injury or violence, and the difficulty cannot be remedied by altering the program or services. In general, an appeal must be initiated within 30 days of the action or decision.[12] If there is rejection of the treatment plan but an appeal is not timely filed, the treatment plan is considered to be accepted by the client or guardian.[13]

E. Termination from a community program.

Regulatory changes[14] effective January 1, 1998 established the following standards that must be followed regarding the termination of a client from a community program which is operated or contracted by the Department:

Every client is responsible, to the extent of his or her ability, for respecting the rights of other clients and staff in the program and conforming to reasonable operational rules and guidelines of the program.

If a client is not meeting this responsibility, the program director or designee must document this situation, including the underlying reasons, and should in conjunction with the client, including the client's legally authorized representative, design a plan to address the problem.

If the plan does not correct the problem, the client may be asked to leave the program, provided, however, that:

(a) Transfer of clients who are receiving individual service plan (ISP) services are also governed by the appeal procedures in the DMH ISP regulations.

(b) No client may be asked to leave a program if an appropriate alternative can substantially resolve the situation.

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[8] 104 CMR 16.05(7), 16.11(2).

[9] 104 CMR 16.09(1)(a).

[10] 104 CMR 16.06(1)(a) and (c), 16.09(1)(c) and (e).

[11] 104 CMR 16.09(1)(c) and (e).

[12] 104 CMR 16.11(3)(c).

[13] 104 CMR 16.05(7)(d).

[14] 104 CMR 28.12.

(c) No client may be discriminated against or asked to leave a program due to the exercise of any right set forth in the DMH communicate regulations (104 CMR 28.00).

The program director must notify the Department if a client is asked to leave a program.

A client who is asked to leave a program may request a review of that decision by the Human Rights Committee or by the Area Office of the Department.

Clients in residential programs may have additional legal remedies, including the protections enumerated under the Community Residence Tenancy Law, described immediately below.

F. Additional requirement regarding residential services.

In addition to the standards, described immediately above, which must be met it a client is to be terminated from any community service, the following requirements apply, by statute, if the services are residential.

Clients in residential programs which are funded, operated or licensed by DMH have the following procedural rights before they may be terminated from the residence.

The client has the right to the normal landlord/tenant summary process proceedings if

1. the client's name is on the lease or
2. the client meets each of the following three conditions: (i) the client pays the program for residential care and services, (ii) the client's residential unit is equipped with a kitchen and bathroom and (iii) the client occupies the unit either alone or with his or her family.

For ALL OTHER community residential programs, the client has the right to a hearing conducted by an impartial hearing officer who is appointed by DMH. The hearing officer may allow termination of residential services only if he/she finds either that (i) the client "has substantially violated an essential provision of a written agreement containing the conditions of occupancy" or (ii) the client "is likely, in spite of reasonable accommodation, to impair the emotional or physical well-being of other occupants, program staff or neighbors."[15]

Clients may obtain representation or other legal assistance with a termination proceeding by contacting the Center for Public Representation or Mental Health Legal Advisors Committee, which are listed in the Resources section near the end of this Handbook.

[15] S. 308, c. 38 of the Acts of 1995, referred to as the Community Residence Tenancy Law.

V. CONSENT TO TREATMENT.

A. Informed consent principles.

In general, clients have the right to control their own treatment and services and to request alternative or additional treatment or services.[16] These rights are found within the principles of "informed consent".

Regulatory changes, effective January 1, 1998, have made explicit the principles and applicability of informed consent. The regulations define "informed consent" to mean the knowing consent, voluntarily given by the client, or his or her legally authorized representative, who can understand and weigh the risks and benefits of the particular treatment being proposed.[17] In other words, consent must be voluntary, knowing and informed - these three terms are discussed below.

Voluntary means that the client must be given the opportunity to make a decision without coercion, and without any retaliation or punishment as a result of making a particular choice. DMH Policy clarifies this point:

> "Loss of privileges, threat/use of restraints, discharge, guardianship, Rogers orders or any form of retaliation and/or coercion may never be used as punishment when a client freely exercises his/her right to refuse/accept treatment. Although such interventions may not be imposed as punishment, they may be utilized in accordance with applicable legal and clinical standards to address the consequences of the client's refusal of treatment."[18]

Knowing means that the client must be able to understand and weigh the risks and benefits of the particular treatment being proposed **- i.e., the client is "competent" to consent. A client who is not under guardianship but who in the opinion of treating professionals is not actually competent to consent, will generally not be allowed to give informed consent.** See discussion of competence in part VIIIA below.

Informed means that the client must be provided certain information so that the client will be able to make an informed choice. DMH policy has set forth the following as the minimum information to be provided a client:

- o a description of the condition being treated;
- o an explanation of the proposed treatment;
- o an explanation of the risks, side effects and benefits of the proposed treatment;

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[16] 104 CMR 27.11(1), 28.02(1)(c), 28.03(1)(j); DMH Patient Rights and Responsibilities Policy # 95-5R, parts III B and C at pages 3-6.

[17] 104 CMR 27.10(1)(a) (the inpatient regs) and 104 CMR 28.03(1)(j) (the community regs).

[18] DMH Policy on Informed Consent for Psychiatric Medications, ECT or Psychosurgery # 96-3R, part VB at pages 3-4.

- a set of materials that are written in common, everyday language describing the benefits, risks and side effects of the proposed treatment;

- an explanation of alternatives to the proposed treatment, including not having treatment, and the risks, benefits and side effects of the alternatives to the proposed treatment;

- an explanation of the right to freely consent to or refuse the treatment without coercion, retaliation or punishment. In cases where a competent client refuses a recommended treatment, alternative, clinically appropriate treatment acceptable to the client, including no treatment, must be explored and offered where possible;

- an explanation of the right to withdraw one's consent to treatment, orally or in writing, at any time.[19]

The above information should also be shared with any guardian.[20]

A consent form should be signed by the client and placed in the file, with a copy of the consent form given to the client, unless the client chooses not to execute a consent form.[21]

B. When informed consent must be obtained.

DMH regulations[22] and judicial decisions[23] require that treatment with antipsychotic medication, Electroconvulsive Treatment (ECT), psychosurgery, involuntary sterilization or abortion, and other highly intrusive or high risk interventions not be administered or performed without the client's informed consent. In the case of a client incapable of giving informed consent, these interventions may not be administered or performed without prior review and approval by a court or the consent of a client's legally authorized representative (e.g., a guardian) who must first have been granted specific authority by a court to authorize the treatment or other procedure.

Prior to an adjudication of incompetence, and court approval of a treatment plan, a client retains the right to accept or refuse the treatment.

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[19]DMH Policy on Informed Consent for Psychiatric Medications, ECT or Psychosurgery # 96-3R, part VB at pages 3-4. See also Rogers v. Commissioner of the Department of Mental Health, 390 Mass. 489 (1983) and DMH Policy No. 83-50, page 4, which describes in some detail the Rogers decision and its requirements regarding informed consent. See also 104 CMR 27.11(1)(b).

[20]A guardian includes a court-appointed guardian of an adult and the parent of client under the age of 18 years (unless the rights of the parent have been limited by a court or voluntary agreement). For a discussion of the role of guardians, see part VIII of this handbook.

[21] DMH Policy on Informed Consent for Psychiatric Medications, ECT or Psychosurgery # 96-3R, part VD4, near the top of page 5.

[22] 104 CMR 27.10(1)(a) (the inpatient regs)and 104 CMR 28.03(1)(j) (the community regs).

[23] See, e.g., Rogers v. Commissioner of the Department of Mental Health, 390 Mass. 489 (1983) and DMH Policy No. 83-50, page 4, which describes in some detail the Rogers decision and its requirements regarding informed consent.

But, for a client who is believed to be incompetent to give informed consent to treatment with antipsychotic medication, the right to refuse such medication may be overridden prior to an adjudication of incompetence and court approval of a treatment plan only in rare circumstances to prevent an immediate, substantial and irreversible deterioration of the patient's mental illness. If treatment is to be continued over the client's objection, and the client remains incompetent, then an adjudication of incompetence and court approval of a treatment plan must be sought.

While the DMH regulations (as described above) require informed consent for antipsychotic medication, DMH Policy applies these same informed consent principles to all psychiatric medication (including antipsychotic medication) and ECT.[24] This Policy is applicable to all DMH operated and funded facilities and programs.

C. Routine and Preventive Treatment.

Routine and preventive treatment includes standard medical examinations, clinical tests, standard immunizations, and treatment for minor illnesses and injuries.

DMH inpatient regulations provide that a client who is capable of giving informed consent regarding routine and preventive treatment has the right to refuse such treatment. But, the refusal may be overridden by the facility or program director, without special court authorization, when the treatment consists of:

(a) a complete physical examination, and associated routine laboratory tests, required by law to be conducted upon admission and at least annually thereafter.

(b) immunizations or treatment required by law or necessary to prevent the spread of infection or disease.[25]

DMH community regulations provide that if the client has no legally authorized representative, the program director may consent to routine or preventive medical care, including standard medical examinations, clinical tests, standard immunizations and treatment for minor illnesses and injuries. However, such medical care may only be authorized upon recommendation of the treating physician that such care is necessary and appropriate, and provided that

(a) the client agrees to such care,

(b) the client is not a minor or under guardianship, and

(c) the client has been found to be incapable at his or her last periodic review.[26]

D. Children.

Consent for the treatment of clients under 18 years must be obtained from the parent or other legal guardian, with the following exceptions. An inpatient facility or community program may determine that a person under the age of 18 is a mature minor and therefore able to consent to treatment, and the program or facility may also decide not to notify the parents.[27] Sixteen- and 17-year-old clients (who are not under a court-appointed guardian)

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[24] DMH Policy # 96-3R.

[25] 104 CMR 27.10(3).

[26] 104 CMR 28.03(1)(j)2.

[27] 104 CMR 25.04. The regulations state that a facility or program should make these determinations in consultation with their legal counsel.

may admit and discharge themselves from an inpatient facility.[28] Certain other "emancipated" minors may give consent to their medical or dental care.[29]

E. Persons under guardianship.

When a client has a court-appointed guardian, it is the guardian who consents to most medical treatment and other services, so long as the court in its guardianship order has given the guardian authority to make these decisions. For these clients, however, special court authorization is required for antipsychotic medication and certain other procedures, as explained above in part VB.

F. Health Care Proxies.

If a client is at least 18 years old and competent, she may choose to have a Health Care Proxy which lets her name another person (called a health care agent) to make health care decisions for her in the event she becomes not competent to make these decisions herself. **Through a Health Care Proxy, a client can either leave treatment decisions up to the judgment of her health care agent or make explicit decisions about her future treatment** - for example, whether to have certain kinds of antipsychotic medications or whether to have extraordinary treatment if she were ever to become brain dead. Clients can also include within a Health Care Proxy instructions to clinical staff regarding other interventions - for example, what the client finds helpful to calm her down in order to avoid the use of restraint or seclusion, or what interventions should be avoided as potentially traumatizing to the client.

The decisions of whether to have a Health Care Proxy, who is to be the health care agent and what treatment is to be accepted/refused are entirely up to the client.

For more information about Health Care Proxies, the client may contact a program or facility's Human Rights Officer or an attorney or paralegal knowledgeable about these issues. (The Resources Section, near the end of this handbook, can be used to help locate an attorney.) Also, the guardianship handbook published by Mental Health Legal Advisors Committee (listed in the Resources Section near the end of this handbook) includes information on Health Care Proxies.

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[28] 104 CMR 27.05(1)(c); DMH Patient Rights and Responsibilities Policy # 95-5R, part III C 11 at page 6, and DMH Policy # 96-3R, part IVA6 at page 3 address the issue of consent to treatment by 16 and 17 year olds but have been, in effect, overridden by 104 CMR 25.04.

[29] There are six categories of minors who may consent to their own medical or dental care pursuant to state statute (MGL c. 112, s. 12F).

VI. VISITORS, MAIL, CLOTHING, TELEPHONE, POSSESSIONS, SMOKING, PRIVILEGES AND OTHER RIGHTS WITHIN FACILITIES AND PROGRAMS

INPATIENT AND IRTP RULES

A. In general.

For adult, child and adolescent inpatient units and Intensive Residential Treatment Programs (IRTPs), DMH regulations effective January 1, 1998 have set detailed standards regarding the rights of clients to receive visitors, send and receive mail, and make and receive telephone calls. DMH policy, applicable to DMH operated inpatient facilities and IRTPs protect additional rights - for example, the right of clients to wear their own clothing and keep and use their possessions.

Some of the rights, in certain situations described below, may be restricted **if necessary to avoid "harm"**[30] **or "serious harm" to the client or others. Restrictions must be as limited as possible and still avoid the harm to the client or others, and a restriction should not occur if there is an alternative, less restrictive way of avoiding the harm.**[31]

The head of the facility or his or her designee must ensure that any limitation or denial of these rights is reviewed with the client and any client representative, and must document in the treatment record of the client each such limitation or denial and the reasons for it.[32]

Since a restriction of one of these rights is a decision made by the facility director or designee, a guardian (whether the parent of a minor or court-appointed guardian) does not have the authority to restrict the rights described below although he should be consulted and his opinion considered when the head of the facility (or designee) determines whether there is sufficient reason for a restriction.

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[30] With respect to restrictions on telephone or visitors, the regulations require (but do not define) "significant harm". Where the DMH Patient Rights and Responsibilities Policy # 95-5R applies, a standard of "harm" is used, and is defined at the top of page 10 of the policy: "Harm" may include physical or psychological harm but must be tangible or concrete, and not hypothetical or insignificant. For example, clinical staff might conclude that a particular visit or telephone call from a person so upset the client that he became highly agitated and regressed in his treatment or became threatening or assaultive. On the basis of this history, clinical staff might conclude that another telephone call or a visit with this person should be restricted for a period of time if necessary to avoid this harm reoccurring. Or, if clinical staff believed that a client was at risk of suicide, there should be a restriction of possessions that might be used by that client to harm herself. The "harm" standard clarifies that it is the policy of the Department that a restriction is only appropriate in order to avoid actual harm to the client or others, as compared to promoting "appropriate" client dress or limiting visits to "good" people, for example, which might be thought to be in the client's "best interests".

[31] 104 CMR 27.13(6); DMH Patient Rights and Responsibilities Policy # 95-5R, part III F at pp. 10-11.

[32] DMH Patient Rights and Responsibilities Policy # 95-5R, part III F at pages 10-11.

If a client believes that a right has been violated, he may ask staff to reconsider their action, may seek assistance from the human rights officer, or may file a human rights complaint.[33]

B. Specific rules for inpatient facilities and IRTPs as established by DMH regulations.

DMH regulatory changes,[34] effective January 1, 1998, establish the following rights and limitations to those rights:

Telephone calls. Clients have the right to reasonable access to a telephone to make and receive confidential telephone calls and to assistance, when desired and necessary to implement this right, provided that such calls do not constitute a criminal act or represent an unreasonable infringement of other persons' right to make and receive phone calls.

A client's rights to access the telephone, as provided above, may be temporarily suspended, but only by the facility director or designee upon concluding that based on the experience of the client's exercise of such right, such further exercise of it in the immediate future would present a substantial risk of serious harm to the client or others and that less restrictive alternatives have either been tried or failed or would be futile to attempt. The suspension may last no longer than the time necessary to prevent the harm, and its imposition must be documented with specific facts in the client's record.

Clients have the right to receive, or refuse, telephone calls from his or her attorney or legal advocate, physician, psychologist, clergy or social worker at any reasonable time, regardless of whether the client initiated or requested the telephone call. This right may not be restricted.

Mail. Clients have the right to send and receive sealed, unopened, uncensored mail However, the facility director or designee may direct, for good cause and with documentation of specific facts in the client's record, that a particular client's mail be opened and inspected in front of the client, without it being read by staff, for the sole purpose of preventing the transmission of contraband.

Writing materials and postage stamps in reasonable quantities must be made available for use by clients. Reasonable assistance must be provided to clients in writing, addressing and posting letters and other documents upon request.

Visitors. Clients have the right to receive visitors of the client's own choosing daily and in private, at reasonable times. Hours during which visitors may be received may be limited only to protect the privacy of other clients and to avoid serious disruptions in the normal functioning of the facility and must be sufficiently flexible as to accommodate individual needs and desires of the clients and their visitors.

A client's rights to visitors, as described above, may be temporarily suspended, but only by the facility director or designee upon concluding that based on the experience of the client's

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[33] See chapter IX of this Handbook for a discussion of how to file a human rights complaint.

[34] 104 CMR 27.13(5).

exercise of such right, such further exercise of it in the immediate future would present a substantial risk of serious harm to the client or others and that less restrictive alternatives have either been tried or failed or would be futile to attempt. The suspension may last no longer than the time necessary to prevent the harm, and its imposition must be documented with specific facts in the client's record.

Clients have the right to receive, or refuse, visits from his or her attorney or legal advocate, physician, psychologist, clergy or social worker at any reasonable time, regardless of whether the client initiated or requested the visit. This right may not be restricted.

Psychological and physical environment. Clients have the right to a humane psychological and physical environment. Each such client must be provided living quarters and accommodations which afford privacy and security in resting, sleeping, dressing, bathing and personal hygiene, reading and writing, and in toileting. This does not include the right to individual sleeping quarters.

Access to legal advocacy organizations. Clients must, upon admission and upon request at any time thereafter, be provided with the name, address, and telephone number of the Mental Health Legal Advisors Committee, Committee for Public Counsel Services, and authorized Protection and Advocacy organizations, and must be provided with reasonable assistance in contacting and receiving visits or telephone calls from attorneys or paralegals from these organizations. Also, the facility must designate reasonable times for unsolicited visits and for the dissemination of educational materials to clients by such attorneys or paralegals.

Complaints. Clients have the right to file complaints and to have complaints responded to in accordance with 104 CMR 32.00 (discussed below in chapter IX of this Handbook).

Human rights information to each client on admission. A member of the admitting staff must give each client, and, if applicable, his or her legally authorized representative, at the time of admission a copy of the rights set forth above, or other materials explaining his or her rights prepared in accordance with Departmental guidelines.

Copies of rights posted and available in facilities. Each facility must post a copy of the rights set forth above in the admitting room of the facility, in each unit, and in other appropriate and conspicuous places in the facility, and must make copies available upon request.

C. Additional rules for inpatient facilities and IRTPs as established by DMH policy.

DMH Policy, applicable to DMH operated or contracted inpatient facilities and IRTPs, sets forth the following additional rights:

Clothing. On an inpatient unit, clients have the right to wear their own clothes unless it is determined that a particular clothing item would likely be harmful to the client or others.[35]

Possessions. Clients on an inpatient unit may keep and use personal possessions, and this right may only be limited if necessary to protect the client or others from "harm".[36] The right

[35] DMH Patient Rights and Responsibilities Policy # 95-5R, part III F at pp. 10-11.

may only be limited or denied to the extent necessary to protect the client or others from harm. Clients have the right to easy access to individual storage space or a storage container for private use.[37]

IRTP rules. Clients in an IRTP have the right to wear their own clothes, keep and use their own personal possessions and have access to individual storage space for private use unless the head of the program (or designee) in consultation with the service planning team determines that the failure to restrict this right would pose a risk of serious physical or psychological harm to the client or others.[38]

Smoking. The DMH policies regarding clients smoking on an inpatient unit that is operated or funded by DMH are the same as for community programs - see discussion below under COMMUNITY PROGRAM RULES, part C.

Privileges. Privileges are the level of freedom a client has to spend time off of an inpatient unit. Privilege levels range from no privileges (i.e., being restricted to the unit) to authorization to leave the buildings and grounds without escort. Each DMH-operated inpatient facility must have a privilege policy which includes the entire range of privileges.[39]

Assignment of privilege level is a clinical decision based on the ability of the client "to manage safely a given privilege level without unacceptable risk of serious harm to self or others." The assignment of privilege level must be the least restrictive privilege category consistent with this criteria.[40] Privileges are considered therapeutic aspects of inpatient hospital treatment and may never be used for punitive purposes.[41]

COMMUNITY PROGRAM RULES.

A. In general.

In a community program, clients have the right to receive visitors, send and receive mail, make and receive telephone calls and keep and use their possessions. However, in certain situations described below some of the rights may be restricted.

The determination to restrict one of these rights is a decision made by the head of the program (or designee) in an adult program or made through the individual service plan for a client in a child/adolescent program licensed by the Office for Children (OFC). Unless this determination is made, consistent with the standards described below, there may be

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[36]The term "harm" is defined above in footnote 30.

[37]DMH Patient Rights and Responsibilities Policy # 95-5R, part III F at pp. 10-11.

[38]DMH Policy # 86-1, issued jointly by DMH and OFC on April 10, 1986, page 25. See also 104 CMR 3.10(7).

[39] DMH Patient Privileges Policy # 96-1, part VI1, near the top of page 3.

[40] DMH Patient Privileges Policy # 96-1, part VI5, at the top of page 5.

[41] DMH Patient Privileges Policy # 96-1, part IV, at page 2.

no restriction. **Restrictions should be as limited as possible and still avoid the harm, and should not occur if there is an alternative, less restrictive way of avoiding the harm.**

Since a restriction of one of these rights is a decision by the program, a guardian (whether the parent or court-appointed guardian) does not have the authority to order a restriction although she should be consulted and her opinion considered when the decision is made as to whether there is sufficient reason for a restriction.

If a client believes that a right has been violated, he may ask staff to reconsider their action, may seek assistance from the human rights officer, or may file a human rights complaint (see chapter IX below for a discussion of human rights complaints).

The rights described in this chapter differ somewhat depending on whether the program is operated for adults, or is a child/adolescent community program licensed by the Office for Children (OFC).

B. Rights of clients within adult community programs.

DMH regulations,[42] effective January 1, 1998, state that clients' rights include but are not limited to the following:

(1) Discrimination: the right to be free from unlawful discrimination on the basis of race, creed, religion, sex, sexual preference, age, physical or mental handicap or degree of handicap.

(2) Religious freedom: the right to religious freedom and practice without compulsion according to the preference of the client.

(3) Voting: the right to vote, unless a minor or under guardianship which expressly restricts such right. Clients must receive reasonable assistance when desired in registering and voting. This assistance must be provided in a non-partisan and non-coercive manner.

(4) Telephone: the right to have reasonable access to a telephone and to make and receive confidential calls and to assistance, when desired and necessary to implement this right, provided that the calls do not constitute a criminal act or represent an unreasonable infringement of other persons' rights to make and receive telephone calls.

(5) Mail: the unrestricted right to send and receive uncensored and unopened mail, to be provided with writing materials and postage in reasonable amounts and to reasonable assistance when desired and necessary in writing, addressing and posting letters and other documents;

(6) Visits: the right to be visited and visit with others, daily and in private, provided that reasonable restrictions may be placed on the time and place of the visit but only to protect the privacy of other clients or to avoid serious disruptions in the normal functioning of the program. Hours during which visitors may be received must be sufficiently flexible as to accommodate individual needs and desires of clients and their visitors.

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[42] 104 CMR 28.03(1). The rights included within these revised regulations have been rewritten but are similar to the rights set forth in previous DMH regulations.

(7) Visits from an attorney or legal advocate, physician, psychologist, clergy or social worker: the right to receive or refuse visits and telephone calls from an attorney or legal advocate, physician, psychologist, clergy or social worker at any reasonable time, regardless of whether the client initiated or requested the visit or telephone call.

(8) Legal representation: the right to be represented by an attorney or advocate of his own or her own choice, including the right to meet in a private area at the program with an attorney or advocate.

(9) Commercial exploitation: the right to be protected from commercial exploitation.

(10) Humane environment: the right to a humane psychological and physical environment. Where applicable to the program model, clients must be provided living quarters and accommodations which afford privacy and security in resting, sleeping, dressing, bathing and personal hygiene, reading and writing, and in toileting. This provision does not mandate individual sleeping quarters.

(11) Complaints: the right to file complaints and to have complaints responded to in accordance with 104 CMR 32.00 (see part IX of this Handbook).

(12) Informed consent: the right to informed consent (see part V of this Handbook).

C. Posting of rights in community programs.

Regulations,[43] effective January 1, 1998 require that the above rights of clients be posted in appropriate and conspicuous places to which clients and family members have access in the program, and be made available to any person upon request.

D. Possessions.

Possessions may be taken from a client in an adult community program only in the circumstances described below:

1. the possession poses an imminent risk of serious physical harm to the client or others,
2. the possession is contraband or is prohibited by law,
3. the client or legal guardian has consented to the confiscation.

If a possession is confiscated, staff must issue a receipt to the client and store it in a safe place until it can be returned to the client, parent or legal guardian. Any restriction must be documented in the client's record and must be reviewed and monitored by the Human Rights Officer and Human Rights Committee. The program must have a written policy regarding possessions.[44]

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[43] 104 CMR 28.03(2).
[44] 104 CMR 28.08.

E. Searches.

Regulatory changes, effective January 1, 1998, provide that clients in adult programs have the right to be free from unreasonable searches of their person or property. The program must have a written policy regarding searches, and clients must be informed of the policy prior to their admission into the program. The written policy must require that, in all except emergency circumstances, clients must

(1) be informed of the search prior to it occurring,
(2) be provided an opportunity to consent to the search, and
(3) be present during the search of their property.[45]

F. Smoking in community programs.

The DMH Smoking Policy # 95-2 provides that a community program (or inpatient facility) that is operated or funded by DMH must develop a smoking policy consistent with the stated purpose of the DMH Policy, which is to provide a safe, healthful environment for all employees, visitors and clients by reducing the risks from smoking, including the risk from passive smoke, the risk of a fire safety hazard and the risk of employee absenteeism, medical care and liability. However, a program or facility mandated by DMH to be JCAHO accredited must "work toward" compliance with the JCAHO smoking standards, instead of being required to have a smoking policy.

In a memorandum entitled "DMH SMOKING POLICY Implementation Guidelines" and distributed with the DMH Smoking Policy, the Commissioner makes it clear that a program or facility may decide to designate a smoking area within the program or facility so long as the risk of exposure to passive smoke to people outside the smoking area is reduced to the extent possible. The memorandum also states in paragraph # 3 that "[i]t is expected that each program's smoking policy will be locally determined, containing rules that are respectful of the rights of all affected individuals and based on the preferences of the clients in that program." Commissioner's Memorandum to Interested Parties, paragraph # 3 (January 10, 1995).

G. Specific rules for child/adolescent community programs which are licensed by the Office for Children (OFC).

Visits. Clients in an OFC-licensed program have the right to visit with their family and other persons unless restricted by court order or by the individual service plan for therapeutic reasons only.[46]

Mail. Clients in an OFC-licensed program have the right to send and receive mail unread by staff, except as necessary to achieve a therapeutic purpose described in the individual service plan. Inspection of mail for contraband may only occur in the child/adolescent's presence.[47]

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[45] 104 CMR 28.08.

[46] 102 CMR 3.05(8)(c). 102 CMR 3.05 describes the rights of clients in community programs licensed by the Office for Children, while 104 CMR 15.03 describes the rights of clients in other DMH funded or operated community programs.

[47] 102 CMR 3.05(8)(h).

Telephone calls. Clients in an OFC-licensed program may have their telephone calls restricted or monitored only for therapeutic reasons which are sufficient to justify the limitation and which are developed in the individual service plan. If phone calls are monitored, the parties to the call must be so informed.[48] In no event may communication with the child/adolescent's social worker, attorney or clergy person be restricted in an OFC-licensed program.[49]

Clothing. Clients in an OFC-licensed program have the right to wear their own clothing and must be given the opportunity to participate in selecting their own clothing.[50]

(The OFC regulations do not include standards regarding other possessions, but the adult standards described above may prove useful as guidelines in addressing these issues in child/adolescent programs.)

[48] 102 CMR 3.05(8)(i).

[49] 102 CMR 3.05(8)(d).

[50] 102 CMR 3.05(3).

VII. CLIENTS' FUNDS.

A client has the unrestricted right to manage/spend his own money unless the client has a guardian, conservator or representative payee who would make these decisions for the client.

However, in adult inpatient facilities operated or contracted with the Department and in adolescent Intensive Residential Treatment Programs (IRTPs) if a client turns over money to the facility or brings money into the facility and it is determined by a clinical evaluation[51] that the client is not able to manage the money himself, the facility will give the client spending money and manage the remainder of the money for him. **The facility must use this money only for purposes which directly benefit the client, taking into consideration the client's needs and desires.**[52] If the client is determined able to manage part or all of the money that has been turned over to the facility, the client has the unrestricted right to manage and spend this money in his sole discretion.[53] See also DMH Policy # 96-4, which governs client funds in DMH-operated inpatient facilities.

In adult community programs, the program director may hold funds given to him by a client or the client's fiduciary, and the client has an unrestricted right to manage and spend these funds unless the client is a minor or has a legal guardian, conservator or representative payee.[54] But, if a clinical evaluation determines that the client is not capable of managing part or all of the deposited funds, the program must develop procedures to advise and assist the client to manage and spend these funds, in accordance with the client's needs and interests.[55] Assistance to a client should be provided so as to allow the client maximum independence and control over her funds, consistent with her capacities.

Client access to or use of funds may not be restricted to control the client (for example, through a plan to reward the client for good behavior) or for the convenience of staff. The client may request and obtain an accounting of how the client's funds were spent.[56] In child/adolescent community programs licensed by the Office for Children (OFC), the program must provide opportunities for the child/adolescent to learn the value of money through earnings, spending, giving and saving.[57]

Available tools for helping a client to manage and spend funds, in order of increasing restrictiveness, are: training and supervision, co-signatory on bank accounts and spending decisions (enforceable only as agreed to within the treatment plan), trust or durable power of attorney, representative payee, conservatorship, and guardianship.

See also the discussion in the next chapter regarding guardians, conservators and representative payees.

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[51] The clinical evaluation must comply with 104 CMR 30.01(3).

[52] 104 CMR 30.02(6) describes the standards for managing and spending these client funds.

[53] 104 CMR 30.02(5).

[54] 104 CMR 30.03(5)(a).

[55] The clinical evaluation must comply with 104 CMR 30.01(3). The regulations, at 104 CMR 30.03(5), provide the standards regarding the program's managing and spending of client funds.

[56] 104 CMR 30.02(7)(d), 30.03(5)(e).

[57] 102 CMR 3.05(7).

VIII. GUARDIANS, CONSERVATORS AND REPRESENTATIVE PAYEES.

A. Competence.

Until a court determines that a person is not competent to make decisions or manage his funds and appoints a guardian or conservator, all persons aged 18 or over are considered legally competent.[58] However, actual competence depends on the ability of the individual to understand enough about a particular situation in order to make an informed decision. The question is: can this particular person adequately understand the risks, benefits and alternatives to this particular decision if given sufficient assistance or information? A competent person is not expected necessarily to make a "wise" or "correct" decision, but would be expected to be able to make a decision that is informed by an understanding of the important consequences of his or her choice and therefore be able to take responsibility for making that choice. An assessment of competence is part of the informed consent process.[59]

In general, only persons who are both legally and actually competent to make a particular decisions are given the opportunity to give informed consent. See discussion above in part VA regarding informed consent.

B. Appointment of guardians, conservators and representative payees.

For clients under the age of 18 years, the parent is the guardian of the client unless a court determines that someone else should be the guardian. Once a client reaches the age of 18 years, he is considered legally competent and the parent is no longer considered the guardian of his son/daughter (no matter how competent or incompetent the client happens to be) unless a court appoints the parent as guardian.

A guardian is appointed by a court to make certain personal and financial decisions for the client if the client is not competent to make these decisions himself. A conservatorship is a limited form of guardianship, placing only the client's financial resources under the control of the conservator. A representative payee is appointed by the Social Security Administration to handle only a client's Social Security benefits and/or other federal benefits.

Guardians reduce and frequently eliminate the control an individual has over many important life decisions - for, example, where to live, what treatment to receive and how to use her money. Conservators and representative payees also result in loss of control by a client of her funds. Therefore, careful consideration should be given before seeking a guardian, conservator or representative payee.

C. When appointment is appropriate.

The Department of Mental Health has decided that, in general, a person should be considered for guardianship or conservatorship only if his ability to make informed decisions regarding his life and/or property is so limited as to create a serious risk to his health, welfare or

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[58] 104 CMR 28.10(2).

[59] DMH Policy on Informed Consent for Psychiatric Medications, ECT or Psychosurgery # 96-3R, part VB1, at page 3.

safety. And, even in these situations a guardian or conservator should not be sought if advice or assistance (or other less restrictive alternative) can be provided to avoid the serious risk to health, welfare or safety. The fact that an individual may even routinely make "bad" decisions is not sufficient for recommending guardianship or conservatorship.[60]

All less restrictive alternatives should be considered first. In order of increasing restrictiveness, alternatives may include advice, training, supervision, special bank accounts, trusts and a representative payee. **A guardianship or conservatorship is best considered only as a last resort and only when there is a responsible friend or family member who is willing to accept this responsibility.** However, if a guardian or conservator is necessary and no friend or family member is available, the court may appoint someone from a list which it maintains.

D. Authority of guardians and conservators.

A full guardianship gives the guardian general authority over the personal and financial affairs of the client and a full conservatorship over only the financial affairs. However, a guardianship or conservatorship may be (and often is) limited by the court in order to allow the client to make certain decisions herself or have control over some of her funds.

But, even if a guardian has general authority, the client still maintains the right to make the more routine, day-to-day decisions - such as, whom to associate with, what to wear and what to say or write. The client also still has the right to participate in treatment planning to the extent of his ability to do so. And, unless a court explicitly finds that a client is not competent to vote, a client under guardianship retains this right.

Also, it is a court, rather than a guardian, that consents to antipsychotic medication, sterilization, admission to an inpatient facility, the provision or termination of life-prolonging treatment and other treatments or interventions which are intrusive or risky. (Questions about what treatment or interventions must be referred to a court, rather than the guardian, should be directed to the DMH legal office.)

If a guardianship/conservatorship is no longer necessary or the guardian/conservator has more authority than is necessary, the court should be petitioned to terminate or limit the guardianship/conservatorship. If the guardian/conservator is not making decisions in the best interest of the client and this cannot be easily corrected, the court should be petitioned to give instructions to or replace the guardian/conservator.

Mental Health Legal Advisors Committee (MHLAC) has published a comprehensive handbook on guardianship and the alternatives - MHLAC's telephone number and address are listed near the end of this handbook in the Resources Section.

E. Health care agent.

A competent, adult client can appoint a health care agent (pursuant to a Health Care Proxy) to make decisions in the event that the client becomes incompetent. See discussion above at the end of part V of this handbook.

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[60] 104 CMR 28.10(3)(a) and (b).

IX. COMPLAINTS; REPORTING ABUSE.

Regulatory changes[61] effective January 1,1998 extend the Department's complaint, investigation and reporting regulations to cover not only DMH operated and contracted facilities and programs, but also, for the first time, DMH-licensed facilities and programs. The regulations change the "person in charge" of the complaint process from the DMH Area Director to the person with day-to-day responsibility for the facility or program and make a variety of changes in the way complaints are investigated and/or resolved.

A. Informal resolution of complaints.

If a client, family member or other person has a human rights concern, this can be addressed by filing a formal complaint with the head of the program or facility (discussed below in part B) or by seeking to address the concern informally. For example, the client could simply ask staff what would be necessary in order to end a particular restriction or may ask a staff person to address a human rights violation rather than filing a formal complaint.

The client (or other person) may also seek the assistance of the human rights officer for advice or advocacy in resolving a complaint informally. The role of the human rights officer is to advocate for the client and, in some situations, the human rights officer may be able to negotiate a resolution satisfactory to the client. For example, the human rights officer may be able to determine whether the client has a particular right under DMH regulations or policy and if so, may then be able to persuade staff to respect this right. Or, the human rights officer may be able to discuss an issue separately with staff and find out whether there may be a middle ground satisfactory to both the client and the staff.[62]

However, regardless of what informal mechanisms are available to the client, the client always retains the right to file a formal complaint with the person in charge of the program or facility regarding any matter which the client believes is dangerous, illegal or inhumane. And, any allegation of abuse or other serious human rights violation should always result in the filing of a formal complaint so that any necessary corrective action can be taken.

B. Filing a complaint with the person in charge.

A client (regardless of age or competence), guardian, family member, advocate, staff member or other person may at any time make an oral or written complaint to the "person in charge"[63] of the program/facility, alleging a dangerous, illegal or "inhumane"[64] incident

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[61] 104 CMR 32.00.

[62] Negotiation strategies for a human rights officer, as well as the general responsibilities of a HRO, are discussed below in part XV of this handbook.

[63] The term "person in charge" is used throughout the regulations and is defined to mean "the person having day-to-day responsibility for the management and operation of the program or facility . . . or his or her designee." 104 CMR 32.02.

[64] "Inhumane" is defined by the regs to mean "without regard for client dignity". 104 CMR 32.02.

or condition.[65] A complaint form is reproduced at the end of this chapter of the Handbook (at page 29).

DMH regulations specifically address how formal complaints are to be filed and resolved in DMH-operated, funded or licensed inpatient facilities, IRTPs and community programs.[66] The DMH regulations provide that the program/facility's Human Rights Officer has a responsibility to assist clients in filing complaints, and must use her best efforts to ensure that an incapable client's interests are protected through representation by an independent attorney or advocate, if necessary or appropriate.[67]

Each staff person also has a responsibility under the regulations to assist a client to file a complaint if asked to do so by the client.[68] Staff have these responsibilities regardless of their views regarding the appropriateness or validity of the complaint.

The regulations further provide that any employee has a responsibility to file a complaint himself with the person in charge if the employee has reason to believe that there has occurred a dangerous, illegal or inhumane incident or there exists a dangerous, illegal or inhumane condition.[69]

The person in charge of the program/facility must ensure that complaint forms and appeal forms are available at well identified locations and are provided to clients upon request.[70] A notice of the availability and general provisions of the DMH complaint regulations must be "conspicuously posted" at the program or facility and must be provided upon admission to each client and any guardian.[71]

C. Complaint procedure under the DMH regulations.

Once a complaint is filed, the DMH regulations require the person in charge of the facility/program to either

1. investigate the complaint and issue a written decision within 10 days, or
2. refer the complaint to DMH Central Office for investigation by the Department if the complaint falls within any one of the following seven categories:
    - medicolegal death,
    - sexual assault or abuse,
    - physical assault or abuse,
    - attempted suicide which results in serious physical injury,
    - a felony has been committed,

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[65] 104 CMR 32.03(1). A complaint may also be filed with any employee, who then must forward the complaint to the person in charge of the facility or program.

[66] 104 CMR 32.00.

[67] 104 CMR 32.05(3). See also the discussion in part XV F below.

[68] 104 CMR 32.05(1)(a).

[69] 104 CMR 32.05(1)(c).

[70] 104 CMR 32.05(2)(b).

[71] 104 CMR 32.05(2)(a).

- restraint or seclusion practice not in accordance with DMH regulations which result in serious physical injury, or
- the person in charge believes that the complaint is sufficiently serious or complicated as to require an investigation by the DMH office of Investigation even though the complaint does not fall within one of the other six categories listed above.[72]

Complaints referred to the DMH Central Office for investigation go either to the Office of Investigations (if the complaint involves a program or facility operated or contracted with DMH) or to the Director of Licensing (if the complaint involves a program or facility that is licensed by but not under contract with the Department). The Director of Licensing coordinates investigation of the complaint with the Office of Investigations. The complaint must be investigated within 30 days (unless an extension is granted), and within 10 days either the Area Director, Assistant Commissioner or Director of Licensing then issues a written decision on the complaint.[73]

Any party to the complaint can request reconsideration of the written decision, and the client (and any person acting on behalf of a client) can also appeal the written decision to DMH - the person within DMH to whom the client may appeal will vary depending on who issued the written decision.[74] In the case of an appeal from a decision of a person in charge, the Deputy Commissioner's decision is final, but in the case of other decisions, a decision by the Deputy Commissioner can be appealed to the Commissioner.[75]

D. Retaliation for filing a complaint.

The regulations explicitly prohibit retaliation against any person who files a complaint with the person in charge alleging a dangerous, illegal or inhumane incident or condition.[76]

E. Mandatory reporting of abuse.

All staff who work in a mental health facility or program also have a statutory responsibility to report immediately to the Disabled Persons Protection Commission (DPPC) any act or omission which results in serious physical or emotional injury to a client aged 18 through 59, inclusive.[77] (The 24-hour DPPC hotline phone number is 1-800-426-9009 or call DPPC at (617) 727-6465 during regular business hours.) Abuse of minors must be reported to the Department of Social Services and abuse of persons aged 60 and over to the Executive Office of Elder Affairs.[78] Any other person (for example, a client, family member, advocate, friend) may also file a complaint of abuse with the above agencies.

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[72] 104 CMR 32.05(2)(d).
[73] 104 CMR 32.03(4), 32.05(2)(d) and 32.05(6)(b).
[74] 104 CMR 32.03(6).
[75] 104 CMR 32.05(7)(b).
[76] 104 CMR 32.03(7).
[77] M.G.L. c. 19C, s. 1 and 10.
[78] MGL c. 119, s. 51A (for minors); MGL c. 19A, s. 15 (for elders).

F. Mistreatment of clients.

No program or facility may mistreat a client or permit mistreatment by its staff. **Mistreatment includes any intentional or negligent act or omission which exposes a client to a serious risk of physical or emotional harm.** The DMH adult community regulations (104 CMR 28.04(1)) explicitly prohibit:

- any unreasonable use of force,
- mental or verbal abuse (e.g., name calling or abusive screaming),
- encouraging a client to mistreat another client,
- transfer (or threat of transfer) of a client for punitive reasons,
- restraint as punishment or primarily for staff convenience, and
- retaliation for reporting a client's rights violation.

DMH COMPLAINT FORM

For Department Use Only
Date Received: _____
Received by: _____
Log #: _____
Referred to: _____ Date: _____

COMPLAINT FORM

(Use back of this form or attach a supplement to provide additional information if there is not enough room below).

1. Name(s) of Complainant(s): Status* Address & Tel # (or Program Name)

a. _____ _____ _____

b. _____ _____ _____

c. _____ _____ _____

2. Name of Person(s) complained of (if any and if known):

a. _____ _____ _____

b. _____ _____ _____

c. _____ _____ _____

3. Other client(s) thought to be harmed by the matter complained of (if any and if known)

a. _____ _____ _____

b. _____ _____ _____

c. _____ _____ _____

4. Person filling out form (if other than above): _____

_____ Date: _____

5. When did matter complained of occur? _____

_____

6. Where did matter complained of occur? _____

_____

7. What happened (be as specific as possible: use back of form and additional sheet if necessary)?

_____

_____

_____

_____

_____

_____

*For "Status", please write "C" if a client, "E" if an employee, "H" if Human Rights Committee, "P" if the person in charge or "O" if other.

X. RELEASE OF RECORDS AND PRIVACY.

A. Access to records.

Clients have a right to privacy concerning their records and treatment. In general, client records are confidential and can be released only under limited circumstances, as described below.

In **adult and child/adolescent inpatient facilities and adolescent Intensive Residential Treatment Programs (IRTPs)**, there is access to records only as follows:

1. to the client's attorney,

2. upon judicial order (not a subpoena) signed by a judge or magistrate, or

3. when the head of the facility (or designee) determines it would be **in the best interests of the client**. The regulations give examples of when it may be in the client's best interests to disclose the records:

   - o when treatment is to be continued at another facility and the client meets the criteria for court commitment,
   - o when access to the record will allow the client to pursue a claim or other legal remedy, or
   - o to ensure that the rights of the client are protected.[79]

Regulatory changes effective January 1, 1998 provide that **access by a client to his/her records** must be allowed unless the head of the facility determines that disclose will result in serious harm to the client, and the head of the facility may require consent from the client's legally authorized representative if the client is under the age of 18.[80] DMH Policy governing DMH-operated inpatient facilities further provides that access by the client must be allowed unless (i) there would likely be serious harm to the client as a result of disclosure, as determined by a clinician who has reviewed the record and is knowledgeable of the client, (ii) the likelihood of harm as a result of disclosure may not be satisfactorily addressed through a staff person reviewing the records with the client, (iii) the denial and reasons for it are reviewed with the client, and (iv) the denial with reasons are noted in the client's record. All denials of access by the client must be reviewed by the facility's chief executive officer or designee.[81]

In **residential programs in the community for children or adolescents (i.e., licensed by Office for Children)**, there is access as follows:

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[79] MGL c. 123, s. 36; 104 CMR 27.17(6)(e), (f). Whenever possible, informed, written consent must be sought from the client, if competent, or the client's legally authorized representative, when access is given under the "best interests" exception described above. 104 CMR 27.18(6)(e).

[80] 104 CMR 27.17(6)(c).

[81] DMH Patient Rights and Responsibilities Policy # 95-5R, part III E 8 at page 8.

1. without consent, to "persons directly related to implementing the child's service plan",

2. with "appropriate" consent, to other persons. The program must have written procedures for release of records to the child (taking into account the child's capacity to understand), parent and "persons not directly related to the service plan".[82]

In **all other adult and child/adolescent community programs** (e.g., all outpatient clinics and adult community residences) there is access as follows:

1. to the client or guardian (either a parent of a minor or a court-appointed guardian) and to anyone else with the informed consent of an adult client or guardian (but records of medical or dental care consented to by a minor may be confidential between the minor and the physician or dentist[83]),

2. to the client's attorney or legal advocate,

3. upon judicial order (not a subpoena) signed by a judge or magistrate, or

4. when the program director (or designee) determines it would be in the client's best interests. The regulations give examples of when it may be in the client's best interests to disclose the records:

- o in a medical or psychiatric emergency,
- o to persons authorized by the Department to monitor the quality of services.
- o when access to the record will allow the client to pursue a claim or other legal remedy, or
- o to ensure that the rights of the client are protected.[84]

In other words, clients in outpatient clinics and adult community residential programs have the absolute right to have access to their records, but during an inpatient stay, access may be limited if it is necessary to protect the client from harm. In most situations where access may upset the client, any potential harm can be minimized by having the client look at the records with a staff person present.

If the client believes the record contains inaccurate or misleading information, the client may prepare a "statement of disagreement" which is then entered in the record.[85]

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[82] 102 CMR 3.03(6) (c) and (d).

[83] MGL c. 112, s. 12F.

[84] 104 CMR 28.09(1), (2). Whenever possible, informed, written consent must be sought from the client, if competent, or the client's legally authorized representative, when access is given under the "best interests" exception described above. 104 CMR 28.09(2)(c).

[85] 104 CMR 28.09(5).

The client or guardian may object to disclosure of records or other confidential information by filing a complaint (see discussion of the complaint procedure, above, in chapter IX).

B. Access to confidential information.

The above principles of confidentiality of client records also protect against disclosure of any information regarding the client's care and treatment. In other words, staff should only provide the name of a client or information about the client's diagnosis, history or care and treatment when the person receiving the information is entitled to access to the client's record, as discussed above.

In addition to the above confidentiality protections, information which is given by the client to a therapist with an expectation that the therapist will keep the information confidential as part of the client-therapist relationship, may not be disclosed unless the client (or guardian) consents to release of the information or the information must be disclosed to protect an identified person who would be at risk of serious harm. Staff should consult with the DMH Legal Office or other attorney before making disclosure of this information without the consent of the client or guardian.

C. Privacy.

Every effort must be made by staff to ensure that the privacy of clients is protected to the degree allowed by the physical surroundings and the available facilities. This principle applies, in particular, during dressing, bathing, toileting, medical examinations and expression of strong emotions.

Private space should not be entered without permission from the client (i.e., knock first and do not go in unless invited) except under the following circumstances:

1. there is reason to believe that there is danger (e.g., smoke, sounds of violence),
2. there is reason to believe that a client's rights are being violated, and
3. routine health and safety inspections, with prior notice to the client, and health emergencies.

XI. RESTRAINT, SECLUSION, ROOM PLANS/TIME OUT AND BEHAVIOR MANAGEMENT.

The standards and expectations described in this chapter are generally taken from DMH inpatient regulations (104 CMR 27.12) and DMH policy # 93-1. The inpatient regulatory standards are applicable to adult[86] and child/adolescent community programs[87], adolescent short-term inpatient facilities and IRTPs[88]. Additional requirements for community or child/adolescent programs or facilities are noted.

A. Definition of seclusion and restraint.

Seclusion. DMH regulations define seclusion as occurring any time a person is both confined and isolated, except when a client is placed in her room for the night. Confinement occurs whenever any attempt to leave the room or space will result in (or the client reasonably believes it will result in) being blocked from leaving or receiving sanctions such as the loss of privileges. Isolation occurs whenever the client is placed alone in a room or enclosed space and either the door is closed or persons are not present at (or within verbal or visual contact of) the open doorway or exit.[89]

Mechanical restraint. A mechanical restraint is any device or physical object used to confine or limit a client's freedom of movement - for example, a device or object to prevent the client from hurting himself or others. However, a device or object necessary for orthopedic, surgical or similar medical treatment is not considered restraint if it is not used to limit a client's voluntary movements.[90]

Physical restraint. Physical restraint[91] is using bodily physical force to limit a client's freedom of movement. But, a client may be held with no more force than is necessary to limit the client's movement.[92]

Chemical restraint. Chemical restraint occurs whenever a client is given medication involuntarily for the purpose of restraining him.[93]

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[86]DMH community regulations apply the DMH inpatient regulations regarding restraint/seclusion, as well as additional community requirements. 104 CMR 28.05(5).

[87]OFC regulations require that DMH child/adolescent programs comply with DMH statutory and regulatory standards regarding restraint. 102 CMR 3.05(6)(h)9.

[88] The DMH restraint and seclusion regulations apply generally to a "facility" which is defined by regulation to include DMH-operated or licensed inpatient facilities, and IRTPs. 104 CMR 25.03.

[89]104 CMR 27.12(4). The DMH statute defines "restraint" to include "confinement in a place of seclusion other than the placement of an inpatient or resident in his room for the night, or any other means which unreasonably limit freedom of movement". MGL c. 123, s.1.

[90]104 CMR 27.12(2).

[91]Holding a client for less than approximately five minutes in a firm and gentle manner for the protection of the client or other person is not considered "physical restraint" under the DMH regulations, and therefore would not require the special justification and documentation described above. 104 CMR 27.12(3).

[92]104 CMR 27.12(3).

B. **Where** restraint/seclusion may be used.

Seclusion is illegal in adult community programs, including residential and partial hospitalization programs.[94] Seclusion may be used in a child/adolescent program or in an inpatient facility only in an emergency (see discussion below in part C). In addition, a child/adolescent program/facility must be specially certified by DMH (or OFC if licensed by OFC) to use seclusion.

Mechanical restraint is prohibited in adult and child/adolescent community programs, including residential and partial hospitalization programs.[95] Mechanical restraint may be used in an inpatient facility only in an emergency (see discussion below in part C).

Physical restraint may be used in the community or inpatient facility only in an emergency (see discussion below in part C).

Chemical restraint is prohibited in the community[96] and may be used in an inpatient facility only in an emergency and with the authorization of a physician (see discussion below in part C).

C. **When** restraint/seclusion may be used.

Restraint or seclusion may only be used in an "emergency". DMH regulations define "emergency" to mean the occurrence or "substantial risk" of serious self-destructive behavior or serious physical assault. A "substantial risk" includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm.[97] Restraint or seclusion may never be used if less restrictive alternatives can be used to address the risk of harm.[98] No PRN or "as required" authorization of restraint or seclusion may be written.[99]

If a violent incident has occurred but restraint or seclusion is not necessary because there is no longer a significant threat of serious harm, restraint or seclusion may not be used. Use of restraint or seclusion in this situation would be punitive and is not allowed.[100] **In other words, restraint or seclusion may only be used if necessary to keep people safe at the present time or in the immediate future.**

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[93] 104 CMR 27.12(5).

[94] 104 CMR 28.05(1).

[95] 104 CMR 28.05(1).

[96] 104 CMR 28.05(1).

[97] 104 CMR 27.12(6). For purposes of seclusion, the OFC regulations define "emergency" as when necessary to protect the child, other children or staff from immediate danger of physical harm. 102 CMR 3.05(6)(l). For purposes of restraint, the OFC regulations define "emergency" as when there is the occurrence of, or serious threat of, violence to self, others or property. 102 CMR 3.05(6)(h).

[98] 104 CMR 27.12(6)(b).

[99] 104 CMR 27.12(6)(d).

[100] 104 CMR 27.12(6)(b): restraint or seclusion may only be used "for the purpose of preventing the continuation or renewal of such emergency condition"; 102 CMR 3.05(h) 2 and 4.

Restraint or seclusion may never be justified if it could have been avoided by staff taking a less confrontational, more empowering approach with the client. For example, a client may react violently to a show of force or to a physical confrontation, but the same client who has a trusting relationship with a particular staff person may be able to calm down by talking or taking a walk with this staff person. The facility staff should seek to establish relationships and interact with clients in ways which minimize the likelihood of a confrontation which may in turn lead to restraint or seclusion.

D. **What should occur** when a client is in restraint/seclusion.

While a client is in restraint or seclusion, staff should seek to make the experience as comfortable and as tolerable as possible for the client - a number of clients have reported being traumatized by the restraint/seclusion experience.

Staff in attendance with the client must use appropriate interventions designed to calm the client.[101] Clients must be fully clothed consistent with client safety and dignity.[102] Staff should also respect the basic human rights of the client to use bathroom facilities accompanied by a same-sex staff person and have adequate food and water, without compromising the safety of staff and clients.

E. **Clients with a history of abuse**: special procedures to identify and assess.

Regulatory changes, effective January 1,1998, require that as part of the intake assessment process, admitting staff of the facility must seek to determine from the client, the client's record, and, where necessary, from other treating clinicians whether the client has a history of being physically or sexually abused.[103]

If there is such a history, staff must further seek to determine:
1. what particular approaches or strategies are most helpful to the client in order to reduce agitation and distress and avoid using restraint or seclusion;
2. what kind of restraint or seclusion, if needed, would be least traumatic for the client;
3. the gender of the staff, if available, who should administer and monitor restraint or seclusion, if used.[104]

For clients with a known history of physical or sexual abuse, reasonable attempts consistent with client and staff safety must be made to ensure that the client's history of abuse and preferences are taken into consideration when the form of restraint is chosen and staff are assigned during a restraint in order to minimize the potential for retraumatization.[105] For example, DMH Clinical Guidelines regarding clients with a history of trauma (issued 8/6/96) note that staff should not use mechanical restraint requiring the client's legs to be spread apart if

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[101] 104 CMR 27.12(8)(f).
[102] 104 CMR 27.12(8)(d).
[103] 104 CMR 27.12(6)(h).
[104] 104 CMR 27.12(6)(h).
[105] 104 CMR 27.12(6)(h).

the client has a history of sexual abuse, unless client preference or practical necessity dictates otherwise.[106]

The Department's Clinical Guidelines include two forms that may be useful to clinicians in implementing the above regulatory requirements - a Trauma Assessment Form and a De-Escalation Form.[107] The Trauma Assessment Form is used to assist clinicians to obtain information from clients regarding any history of abuse. The De-Escalation Form is used to guide staff in working with the client to determine what strategies will be most effective to avoid the use of restraint and seclusion and, if restraint is needed, to minimize any retraumatization from its use. The De-Escalation Form has also proved effective in working with clients who do not have a history of abuse.

F. **Temporary relief** from restraint/seclusion.

Except when the client is sleeping or when precluded for safety reasons, the client must be allowed out of restraints or seclusion for a temporary relief period for at least 10 minutes every two hours from 8:00 AM to 8:00 PM and at east en minutes every four hours from 8:00 PM to 8:00 AM.[108]

G. **Permanent release** from restraint/seclusion.

As soon as restraint or seclusion is no longer necessary to protect clients or staff from serious harm, the client must be released.[109] Clients who are quiet in restraint or seclusion are to be allowed out of restraint/seclusion for a free trial period if it is safe to do so. If they express verbally and behaviorally they have regained control, they may not be put back in restraint/seclusion.[110]

Regulatory changes effective January 1, 1998 require that a client in restraint or seclusion be continuously assessed by staff in attendance for readiness to be released from restraint or seclusion. This assessment must be documented at least every 30 minutes.[111]

H. **Training** of staff regarding restraint/seclusion.

Placing and maintaining a client in restraint or seclusion can be a difficult and sometimes dangerous process. And, the use of restraint and seclusion is governed by extensive laws, regulations and policies.

Accordingly, no staff person should attempt to use restraint or seclusion until he or she has been adequately trained by the program or facility.[112]

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[106] DMH Clinical Guidelines - "DMH Clients with a History of Trauma", issued 8/6/96, page 2

[107] DMH Clinical Guidelines - "DMH Clients with a History of Trauma", issued 8/6/96.

[108] 104 CMR 27.12(8)(e).

[109] 104 CMR 27.12(6)(c) and (13)(d).

[110] DMH Policy # 93-1 (paragraph 6), adopted by DMH on May 20, 1993.

[111] 104 CMR 27.12(13)(a).

[112] DMH regulations require a facility to train staff regarding the use of restraint and seclusion, and less restrictive alternatives. 104 CMR 27.12(6)(g).

Training should include:
1. when and where restraint/seclusion may be used,
2. how to avoid the use of restraint/seclusion through less restrictive alternatives,
3. how to restrain a person safely and humanely,
4. what should be done while a person is in restraint/seclusion,
5. when a client must be released from restraint/seclusion and
6. who must authorize and review the restraint/seclusion.

I. Documentation and review requirements regarding restraint/seclusion.

Each restraint/seclusion must be appropriately documented on the DMH form and must be authorized as provided for in the facility's policies and DMH regulations.[113] Restraint/seclusion forms are reviewed by the human rights officer and committee.[114]

Within 24 hours of release, the client must be given a copy of the restraint/seclusion form and a comment sheet.[115] If the client does not want to comment within 24 hours, staff should request comments at a later time.[116] The client should be encouraged to give meaningful comments regarding the restraint/seclusion experience, how the restraint/seclusion might have been avoided and whether the client has any human rights concerns regarding the restraint/seclusion.

J. Room plans, time out and behavior management.

DMH has no policies or regulations regarding room plans or time out in an adult program/facility. However, an appeals decision by the DMH Deputy Commissioner for Operations explained that with respect to room plans, at a minimum, there should be (i) a properly developed treatment plan which includes the room plan and (ii) consent from a client (who is competent to consent) or consent from a guardian (who has the authority to consent to a room plan).[117]

DMH regulatory changes, effective January 1, 1998, state that "behavior management" may only be used in Department inpatient units which admit clients under 19 or facilities licensed by DMH to provide inpatient services to persons under the age of 19 or licensed as an IRTP. The Department's regulations require a facility which intends to use behavior modification to have a behavior management plan, which must be approved by the Department and must be reviewed by the Human Rights Officer and, where applicable, the Human Rights Committee.[118]

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[113]See 104 CMR 27.12(9) & (10) for authorization requirements. See also 104 CMR 27.12(14) for documentation requirements. See also 104 CMR 27.12(15) for additional requirements for minors.

[114]104 CMR 27.12(14)(e).

[115]104 CMR 27.12(14)(c).

[116]See the staff instruction section of the DMH patient comment form.

[117]Memorandum from DMH Deputy Commissioner for Operations, dated 5/11/93, page 2.

[118]104 CMR 27.10(7). The regs set out a variety of requirements regarding the content of the plan.

The Departments regulations set out a variety of limitations on the use of behavior management. The more important limitations include the following:

1. No behavior modification techniques which involve corporal punishment, infliction of pain or physical discomfort, or deprivation of food or sleep may be used.
2. The treatment plan for each client for whom behavior management will be employed shall contain specific, individualized behavior management interventions, consistent with the program's behavior management plan. The treatment plan including behavior management interventions may not be instituted without the consent of the client or his or her legally authorized representative.
3. Each behavior management plan must describe behavior management interventions that may be used.
4. When feasible and appropriate, clients must participate in the establishment of rules, policies and procedures for behavior management.
5. Upon admission, the facility must provide clients and their legally authorized representatives with a copy of the facility's behavior management plan.[119]

Any facility behavior management plan which provides that a client may be separated from the group or facility activities must include at least the following:

1. guidelines for staff in the utilization of such procedures;
2. persons responsible for implementing such procedures;
3. the duration of such procedures, including provisions for approval by the facility director or his or her designee of a period longer than 30 minutes;
4. a requirement that clients be observable at all times and that staff shall be in close proximity at all times;
5. a procedure for staff to directly observe the client every 15 minutes;
6. a means of documenting the use of such procedures if used for a period longer than 30 minutes including, at a minimum, length of time, reasons for this intervention, who approved the procedure, and who directly observed the client at least every 15 minutes;
7. a time out room may not be locked.[120]

OFC regulations require that child/adolescent community programs, which force a client to go to a room apart from others, have a behavior management policy with

1. guidelines for staff utilizing the room apart from others,
2. persons responsible for implementing such procedures,
3. the duration of such procedures, including procedures for the approval of the chief administrative person or designee for a period longer than 30 minutes,
4. a requirement that the client be observable at all times and in all parts of the room and that staff must be in close proximity at all times,
5. a procedure for staff to directly observe the client at least every 15 minutes,
6. a means of documenting the use of such an area if used for a period longer than 30 minutes including, at a minimum, length of time, reasons for this intervention, who approved the procedure and who directly observed the client at least every 15 minutes.[121]

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[119] 104 CMR 27.10(7).
[120] 104 CMR 27.10(7).
[121] 102 CMR 3.05(6)(i).

XII. LEGAL STATUS OF CLIENTS IN AN INPATIENT FACILITY.

A. Admission.

If a client is admitted to a hospital or other inpatient facility as a ten-day involuntary patient (on a "pink paper") and he is competent, **he has the option to become a conditional voluntary patient.**

As a conditional voluntary patient, he will remain at the hospital until the hospital decides to discharge him or he asks to leave by submitting a three-day notice (see discussion below of three-day notice). If he does not want to sign a conditional voluntary paper or is not competent to do so, he will be either discharged by the end of the ten-day period or the hospital will file a court petition for his commitment (see discussion of court petition for commitment below). He has the right to consult with an attorney or someone working under the supervision of an attorney prior to agreeing to be a conditional voluntary patient.

B. Three-day notice.

If a client submits a three-day notice, the hospital can detain him for three days (Sunday, legal holidays and the day he submits the notice are excluded). During the three days, the hospital assesses him. If the hospital decides that he is mentally ill and there is a likelihood of serious harm if he leaves, the hospital may file a court petition for his commitment (see discussion of court petition for commitment below). He would then be held at the hospital until a judge makes a decision regarding the commitment. If the hospital does not file a petition for commitment by the end of the three-day period, he may leave the hospital.

C. Court petition for commitment.

If a petition for commitment is filed, the client has the right to:

1. Notice of the time and place of the court hearing, and the opportunity to attend the hearing.
2. Appointment of a free lawyer to represent him, unless he can afford a private attorney.
3. Request an independent psychiatric examination (request this through the lawyer appointed to represent him).
4. A full hearing.

The client may be kept at the hospital until the judge makes a decision after the hearing. The judge will either order that he be discharged immediately or committed to the hospital for up to six months (the first commitment) or up to one year (subsequent commitments). However, the hospital must discharge him at any time that it believes he is no longer in need of care and treatment. He also has the right to appeal a judge's commitment order.

XIII. DISCRIMINATION IN THE COMMUNITY.

A. Introduction.

All persons have the right not to be discriminated against because of a mental or physical disability. In other words, a person may not be excluded, denied opportunities or benefits or otherwise discriminated against on account of his or her mental illness or history of mental illness or on account of his or her physical disability. Federal and state laws prohibit discrimination with respect to housing, employment, places of public accommodation (e.g., restaurants, movies and banks), health care facilities and many other services and benefits generally offered to the public. **Persons who may have been discriminated against may be referred to the Disability Law Center or the Center for Public Representation.**[122]

B. Housing.

A landlord may not deny housing to someone because of her mental illness, history of mental illness or physical disability.[123] The landlord has a responsibility to make a reasonable accommodation in its rules, policies, practices, services and the premises if necessary to allow the tenant full use and enjoyment of the apartment. The landlord does not have to make an accommodation if it would impose on the landlord an undue hardship.[124]

An accommodation might include relocating the tenant within the building, inserting soundproofing materials in the apartment, educating security persons regarding any special needs of a tenant with mental illness, allowing the tenant sufficient time and opportunity to obtain counseling or other assistance or making a reasonable modification to the normal rules or expectations in the apartment building. With an accommodation, the tenant must be able to meet the usual requirements of tenancy such as timely payment of rent.

C. Employment.

State and federal laws also prohibit discrimination against persons with mental illness, history of mental illness or physical disability in regard to employment. In order to be protected, the person must be able to perform the essential functions of the job, with a reasonable accommodation. The employer need not make an accommodation if it would impose an undue hardship on the employer or other employees.[125] An accommodation might include restructuring the job, allowing a job coach to assist the employee or permitting the employee additional time off to seek counseling or other treatment or assistance.

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[122] These organizations are listed in the Resources Section which is near the end of this handbook.

[123] M.G.L. c. 151B, s. 4, subs. 6 and 7, prohibiting discrimination in all rental housing other than owner-occupied two-family housing. Federal law also protects persons from housing discrimination. See the federal Fair Housing Act, 42 U.S.C. 3601 et seq.

[124] M.G.L. c. 151B, s. 4, subs. 7A.

[125] M.G.L. c. 151B, s. 1, subs. 16 and 17, and s. 4, subs. 16. This law does not cover employers with fewer than 6 employees. M.G.L. c. 151B, s. 1, subs. 5. See also the Americans with Disabilities Act.

XIV. HUMAN RIGHTS POLICIES AND PRACTICES.

The Department of Mental Health has a comprehensive Human Rights Policy (Policy # 95-4) which describes the required human rights policies and practices for any program or facility which is funded or operated by DMH. Much of what appears below in this chapter and chapters XV and XVI of the handbook is taken from the DMH Human Rights Policy.

The Human Rights Officer and the Human Rights Committee (described below) have a particular responsibility to ensure protection of the human rights of all persons served by the program/facility. But, the protection and enhancement of human rights is a common objective to be shared by all staff, with a special responsibility of senior staff and managers to provide the leadership and establish the values necessary to implement human rights on a day-to-day basis. It is anticipated that all persons within the Department and in program/facilities operated or funded by the Department will work together in a cooperative and collaborative manner toward this end.[126]

A. Practices and Policies to Ensure Clients' Rights.

1. Human Rights Officer. Each program or facility must have a Human Rights Officer, with roles and responsibilities described below in chapter XV of this handbook. The program/facility must establish safeguards to ensure the independence of the Human Rights Officer (HRO) (within the parameters of what is possible in the program/facility), and must ensure that the HRO is given adequate time and resources to carry out his or her human rights responsibilities.

2. Human Rights Committee. Human Rights Committees must be appointed so that each program/facility that is operated or funded by DMH is overseen by such a committee. Chapter XVI of this handbook describes how this is accomplished.

3. Human rights policy. Each program/facility must have a written human rights policy (and must implement practices) to ensure that clients' rights are respected, including but not limited to clients' rights described in statutes, regulations and policies. The DMH Area Office must review and approve the program/facility's human rights policy.[127]

4. Human rights training plan.

Each program/facility must also have a written training plan (reviewed and approved by the DMH Area Office[128]) to ensure that

- staff are trained to understand and respect client rights and responsibilities, both at orientation for new staff and periodically for all staff (see part XVIII of this handbook for human rights training standards for staff);

- clients are trained to understand and implement their own rights and responsibilities.

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[126]DMH Policy # 95-4, page 3.

[127]DMH Policy # 95-4, page 4.

[128]DMH Policy # 95-4, page 4.

B. Information for clients.

The program/facility must prepare for clients and their legal guardians written information on client rights and responsibilities. The program must distribute a copy of the written information to each client (and any legal guardian) upon admission of the client into the program, and must make the written information available at any time thereafter upon request.[129]

The written information on clients rights and responsibilities must include a description of the role of the legal guardian in making decisions, participating in treatment planning and otherwise protecting the rights of children, adolescents and others under guardianship.

The written information on client rights and responsibilities must address the following:

- rights regarding client participation in treatment (and discharge) planning to the maximum extent possible,
- rights regarding commitment and discharge options in inpatient facilities,
- limitations on the use of restraint, seclusion and room restrictions (to the extent allowed by DMH regulations and policy and used by the program),
- right to refuse antipsychotic medications and other treatment,
- management and expenditure of clients' funds (if a residential or inpatient program),
- health care proxies (for adults),
- the procedures for filing a human rights complaint (under 104 CMR 24 or as otherwise specified by DMH contract) and any other processes for resolving concerns or complaints,
- the procedures for filing a complaint of abuse with the Disabled Persons Protection Commission (for persons aged 18 through 59), the Department of Social Services (for persons under the age of 18) and the Executive Office of Elder Affairs (for persons over the age of 59),
- the role, responsibilities and availability of the Human Rights Officer and Human Rights Committee, and
- the availability of legal advocates.[130]

The clients rights information for inpatients must also include rights described in 104 CMR 3.10 (as applicable), and for clients in the community must also include the rights described in 104 CMR 15.03 (as applicable).

The program/facility must ensure that all clients know about and have access to this written information regarding client rights and responsibilities, that all clients know of the availability of the appropriate complaint procedures and that all clients know of the HRO's availability to explain and/or assist with anything discussed in the client rights and responsibilities written information.

A summary of the above client rights and responsibilities, and a notice of availability of the Human Rights Officer (and how to contact him or her) must be posted in a prominent place in

[129]DMH Policy # 95-4, page 4.

[130]DMH Policy # 95-4, page 5.

each program/facility (including each inpatient ward). (Note that DMH Informed Consent Policy # 96-3R, part VIID, requires a separate posted document on informed consent rights.) If a program is supported housing with clients as leaseholders, the clients living in the program may decide not to have such a posting displayed.

Written rights and responsibilities information must use words understandable to the client, must be translated into appropriate languages for persons whose primary language is not English and must be made accessible to any persons who have a sight impairment. The written information must also be age-appropriate - e.g., take into consideration the rights of children/adolescents in programs/facilities serving these age groups.

The program/facility must provide a copy of the above client rights and responsibilities information (and the posted summary) to the DMH Area Office for review and approval.[131]

C. Access by legal advocates.

Each facility/program must comply with federal statute, 42 USC 10805 and state law M.G.L. c. 221, s. 34E, to provide reasonable access by advocates of the Massachusetts Mental Health Protection and Advocacy Project (MHPAP), the Mental Health Legal Advisors Committee (MHLAC) and other legal services agencies funded by the Massachusetts Legal Assistance Corporation under MGL c. 221A to provide free legal services to clients. Reasonable access must include access at reasonable times to all clients and inpatient units for the purpose of providing information to clients about their rights, with or without a specific request of a client or clients. In addition, any attorney (or legal advocate or paralegal working under the supervision of a MHPAP or MHLAC attorney) who represents a client, must have access to the client, the client's records, the hospital staff responsible for the client's care and treatment, and any meetings that the client attends or has the right to attend.[132]

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[131]DMH Policy # 95-4, pages 5-6.

[132]DMH Policy # 95-4, page 6.

XV. HUMAN RIGHTS OFFICERS.

A. In general.

Regulatory changes, effective January 1, 1998, extend to private hospitals licensed by DMH the basic regulatory requirements for having a Human Rights Officer.[133] DMH community regulations continue to require a Human Rights Officer in community programs operated, licensed or contracted for by DMH.[134]

Each program/facility must have a Human Rights Officer. The Human Rights Officer must spend sufficient time at the program/facility site so that clients at the program/facility have regular and frequent opportunities to come in contact with and request assistance from the HRO. This may occur by appointing as Human Rights Officer either a staff person who works at the program/facility site or a staff person who visits the program/facility on a regular and frequent basis. However, the Human Rights Officer may not be the head of the program/facility.

The Human Rights Officer must, to the extent possible, have no duties which are inconsistent with his or her responsibilities as a Human Rights Officer and must be given adequate time, resources and support to carry out his or her human rights responsibilities.

It is recommended that a Human Rights Officer for inpatients have no clinical responsibilities for persons served as inpatients of the facility. This is because an inpatient client's human rights concerns or complaints often involve decisions by his or her clinicians, and it then may become difficult for the clinician to advocate for the client as a human rights officer.[135]

B. Qualifications.

The qualifications of a Human Rights Officer include having a deep appreciation for the dignity and worth of persons with mental illness, and a personal commitment to the protection of human rights. He or she must be able to be a strong advocate for all of the clients in the program/facility, and at the same time work cooperatively and effectively with program/facility staff and the Human Rights Committee to ensure that the program/facility fully respects the human rights of those persons whom it serves. It is preferred that a staff person have had mental health or human services education or experience before being appointed as the HRO. The

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[133] 104 CMR 27.14(1), which states as follows:
"Each facility shall have a person or person employed by or affiliated with the facility appointed to serve as the human rights officer and to undertake the following responsibilities:
(a) To participate in training programs for human rights officers offered by the Department;
(b) To inform, train and assist patients in the exercise of their rights;
(c) To assist patients in obtaining legal information, advice and representation through appropriate means, including referral to attorneys or legal advocates when appropriate;
(d) In the case of Department facilities, to serve as staff to the facility's human rights committee. In the case of Department facilities, the Commissioner or designee shall appoint the human rights officer. Otherwise, the facility director shall make such appointment."

[134] 104 CMR 28.11(7).

[135] DMH Policy # 95-4, pages 6-7.

Human Rights Officer must be able to carry out the responsibilities described below in parts XV E and G of this handbook.[136]

C. Advocating for the client while employed by the program/facility.

The mandate of the Human Rights Officer to empower the client by reflecting the client's perspective typically occurs in the context of working as a staff member employed by and reporting to someone within the program or facility. There are inevitable tensions that may be felt between advocating for the client and fulfilling one's other duties and responsibilities within the program/facility.

There are a number of important principles that may be followed in order to work effectively within this context. First, it will be necessary to have clear and explicit support from the program or facility director for the human rights officer to carry out her responsibilities.

Second, it is important to recognize that the protection and enhancement of human rights is a common objective, to be shared by all program/facility staff. It is the particular responsibility of the program/facility director clearly to convey this message to staff and to seek their participation and cooperation.

Third, it is important for the Human Rights Officer to seek to understand the perspective of the clinical and administrative staff. The human rights officer should seek to identify and propose solutions which meet the concerns of clinical and administrative staff and at the same time preserve the human rights of the client.

Finally, the Human Rights Officer should understand how problems and potential conflicts can be resolved through negotiations (discussed below in part H) which need not be threatening or divisive, and to appreciate how to utilize the least formal and least disruptive methods of assistance first in order to minimize the potential for confrontation or embarrassment.

D. Disciplining a Human Rights Officer.

A Human Rights Officer may not be disciplined or discharged for appropriately carrying out his/her human rights responsibilities or may in any way be discouraged from appropriately carrying out such human rights responsibilities.[137]

E. Summary of Responsibilities of a Human Rights Officer.

The responsibility of the Human Rights Officer is to enable the program/facility to fully respect the human rights of the persons served by the program/facility. This occurs through proactive measures, such as education of staff and recommendations of systemic changes, and through assistance to individuals served by the program/facility, as described in more detail below.

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[136]DMH Policy # 95-4, page 7.

[137]DMH Policy # 95-4, page 4.

In the performance of his or her duties, the Human Rights Officer must clearly and consistently act to ensure that the points of view of the persons served by the program/facility are understood and respected. When an individual is able to understand the implications of a decision, the Human Rights Officer must accept the articulated perspective of the individual rather than assume that some other position is in his or her best interests. When, by reason of age or competence, the individual is not able to understand the implications of a decision, the human rights officer must nevertheless seek to learn the point of view of the individual and to ensure that this point of view is understood and respected by others to the fullest extent possible.[138]

The work of the Human Rights Officer will depend somewhat on the nature of the facility or program/facility. Locked facilities tend to require the most active human rights monitoring and protections because of the involuntary nature of the hospitalization and the use of restraint or seclusion. Outpatient clinics tend to require the least involvement, although there may be important human rights issues regarding confidentiality, access to records, participation in treatment decisions and planning, and discrimination in the community.

The specific responsibilities of a Human Rights Officer (discussed in more detail in part F below) include the following:

- Assist the Human Rights Committee (that oversees the HRO's program/facility) in its efforts to review and monitor the implementation of the rights of clients within that program/facility, report to the Committee regarding the HRO's activities and meet with the Committee for these purposes.

- Advocate for and assist any client whose rights have been, are being or are at risk of being denied.

- Assist in resolving through all available mechanisms the client's human rights issues.

- Participate in all quality management activities relevant to human rights.

- Participate in the development of the program/facility's policies and practices, as well as other program/facility initiatives, relevant to human rights.

- Review all complaints and all citizen monitoring reports.

- Educate and inform clients of their rights, including the right to file a complaint.

- Inform legal guardians of their role in making decisions, participating in treatment planning, and otherwise protecting the rights of children, adolescents and others under guardianship.

- Seek out clients who would not likely independently approach the HRO but who may have a human rights concern.

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[138]DMH Policy # 95-4, page 7.

- As soon as possible and preferably within 72 hours of the client's admission, personally meet with and inform each client of his/her rights (including the right to consent to and refuse treatment[139]) and the role and availability of the Human Rights Officer.

- Assist clients (and their legal guardians) in obtaining an attorney or legal advocate when they request one or when it is in their best interest to have one in the opinion of the HRO or HRC (see list of legal assistance offices in the Resources section near the end of this handbook).

- Be available to explain to clients, who are over the age of 18 years, their rights under the Massachusetts Health Care Proxy law, and refer to an outside attorney or legal advocate any eligible client who desires assistance to execute a Health Care Proxy.

- Educate staff at orientation and at other times regarding the rights and responsibilities of clients and the role of legal guardians in making decisions and participating in treatment planning on behalf of the client.

- Advise and consult with the Area's human rights coordinator regarding challenging human rights issues (including but not limited to the continuing use of restraint, seclusion or room restrictions, and any pattern or practice of alleged violation of client rights).

- Attend all training sessions sponsored by DMH for Human Rights Officers.

- Have access to clients, client records, incident reports, program/facility policies, program/facility staff at all levels, and meetings relevant to a client's rights in order to carry out the previously listed responsibilities.[140]

See part G below for additional responsibilities regarding restraint, seclusion and other forms of room restrictions.

F. Explanation of the Responsibilities of the Human Rights Officer.

The role of the human rights officer is to ensure that the program/facility respects the human rights of each client. Most of this task will be accomplished if the client is respected and valued as a person and if the program/facility complies with the policies, regulations and laws that govern it.

DMH regulations and policy outline the specific responsibilities of the human rights officer. Perhaps most important of the enumerated responsibilities is "to inform, train and assist

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[139] DMH Policy on Informed Consent for Psychiatric Medications, ECT or Psychosurgery # 96-3R (part VIIA) requires the HRO to meet with and advise the client regarding the client's rights, including the right to consent to and refuse treatment.

[140] DMH Policy # 95-4, pages 7-9.

clients served by the program/facility in the exercise of their rights,"[141] and much of what is written below explains the content of this phrase.

1. Assisting clients to exercise their rights. The human rights officer has responsibility to advocate for and assist any person served by the program/facility whose human rights allegedly have been, are being or are at risk of being denied. The human rights officer should use whatever internal program/facility procedures and communications may be available to seek protections of the individual's rights, including but not limited to making inquiry into allegations of the denial of rights, meeting with appropriate clinical and administrative staff, negotiations on behalf of a person served by the program/facility, assisting an individual to file a complaint or filing a complaint on his behalf or filing an individual service plan appeal.

2. Monitoring clients' rights. Working with the human rights committee, the human rights officer should monitor any limitations on rights. The human rights officer should review all complaints and written decisions regarding complaints (104 CMR 24.03 and 24.05) in order to understand the concerns of clients and to identify potential human rights violations. The human rights officer may also find it useful to monitor all accident and injury reports, all incident reports, treatment plans, and other reports or documents reflecting a limitation on or an alleged violation of a client's rights.

3. Assistance may vary depending on the abilities of the client. The human rights officer should make a special effort to monitor and assist persons who are not capable of making a request for assistance to the human rights officer or who are not capable of advocating for themselves. For those clients who are able to advocate for themselves, the human rights officer may find it best to empower the client to advocate for herself by providing information and encouragement rather than acting on behalf of the client.

4. Informing clients of their rights. The human rights officer should take steps necessary to inform all of the persons served by the program/facility of their human rights, including the opportunity to file complaints and the availability of the human rights officer to assist them. This should include distribution to newly-admitted individuals of written materials (in language which a lay person can easily understand) describing their human rights and identifying the human rights officer, periodically attending community meetings to discuss human rights, reminding clients of the role of the human rights officer, advising individuals of their rights upon request and posting in a conspicuous place a notice of human rights and the name of the human rights officer.

With respect to inpatient units and 24-hour residential facilities, the DMH Informed Consent Policy # 96-3R, part VIIA, also specifically provides that:

> "a human rights officer shall introduce himself/herself to a client as soon as possible and preferably within 72 hours of admission to inform the client of her/his human rights, including informed consent, and the right to refuse treatment, accept treatment, or request

[141] 104 CMR 27.14(1)(b) (for inpatient programs and IRTPs) and 104 CMR 28.11(7)(c) (for community programs)

alternative treatment. The human rights officer will also answer any questions or provide additional information if requested to do so."

5. Training clients and staff. In addition to informing clients of their rights on an informal and ad hoc basis as described above, the human rights officer (or another person) should develop and implement a plan to train all of the program/facility's clients regarding their human rights. Training assistance from persons both within and outside the program/facility may be useful.

The human rights officer (or another person) should also educate staff regarding the rights of persons served by the program/facility. This should occur as part of staff orientation as well as at other formal and informal educational opportunities as appropriate.

6. Legal information, advice and representation. The DMH regulations provide that a human rights officer's responsibilities include assisting "clients in obtaining legal information, advice and representation through appropriate means, including referral to independent attorneys or legal advocates, when appropriate."[142] The human rights officer should develop and maintain a current referral list of attorneys and legal advocates. Near the end of this handbook is a page entitled "RESOURCES" which includes legal assistance resources.

7. Human rights training for the HRO. The regulations require the human rights officer to "participate in training programs for Human Rights Officers offered by the Department."[143] In order to carry out his responsibilities, it will be necessary for the human rights officer to have a comprehensive, working knowledge of the rights of clients and how those rights may be implemented. Training programs can assist the human rights officer in this regard, as well as provide needed collegial and professional support.

8. Staff to the human rights committee. The DMH regulations provide that the human rights officer is to "serve as staff to the program's Human Rights Committee."[144] The human rights officer should attend meetings of the human rights committee responsible for the program/facility. At human rights committee meetings, the human rights officer should report to the committee regarding his or her human rights activities and any particular human rights concerns or issues pertaining to the program/facility (for example, difficult individual human rights issues or program policies or practices impacting upon human rights). The human rights officer may also perform certain tasks for the committee (for example, review of restraint reports, suggesting agenda items for the meetings and assisting with recruitment of new committee members) and may serve as liaison between the committee and the head of the program/facility and other staff.

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[142] 104 CMR 27.14(1)(c) (for inpatient programs and IRTPs) and 104 CMR 28.11(7)(d) (for community programs)

[143] 104 CMR 27.14(1)(a) (for inpatient programs and IRTPs) and 104 CMR 28.11(7)(a) (for community programs)

[144] 104 CMR 27.14(1)(d) (for inpatient programs and IRTPs) and 104 CMR 28.11(7)(b) (for community programs)

G. Additional responsibilities regarding restraint and seclusion, and other forms of room restriction.

DMH Policy # 95-4 (pages 9-10) require the Human Rights Officer to review and monitor individual incidents of restraint and seclusion (R/S), room restrictions (e.g., "room plans" - the planned restriction of the client to his/her room), as well as general practices and trends by performing the following tasks. The HRO must:

- Receive a copy of each DMH-approved R/S form (including the client comment sheet) within 48 hours, excluding weekends and holidays, of the R/S incident.

- Be notified of any room plan prior to its implementation, and a copy of the room plan must be sent to the HRO's office before the beginning of the next business day. The notification to the HRO may be given in writing or may be given orally by a telephone call if the HRO is in his/her office or by a message on the HRO's office voice mail if the HRO is not at the facility or is at the facility but not in his/her office.

- Review all R/S forms (and client comment sheets), room plans and other relevant documents as necessary to identify any client concerns and other human rights issues regarding the use of R/S and room restrictions (timely review of these documents by members of the Human Rights Committee may assist the HRO to accomplish this task).

- Follow through with clients and/or staff to address human rights concerns identified on R/S forms (and client comment sheets) and ensure that complaints are filed as necessary to address any illegal, dangerous or inhumane incident or condition.

- Monitor R/S, room restriction practices, policies and training; monitor any use of extended R/S or room restrictions for individual clients; monitor circumstances which generally tend to lead to violence or confrontation. Follow through with clinical and/or administrative staff to address any particular concerns.

- Participate in the multidisciplinary team review of the assessments and treatment plans of clients who are in R/S for 8 hours per 24 hour period, in R/S more than 3 times per week or in R/S more than 5 times per month.

- Receive, review and give to the Human Rights Committee the program/facility's aggregate quality assurance data regarding R/S.

- Make recommendations to the program/facility regarding ways to reduce R/S and other forms of room restrictions and to make them more humane.

H. Negotiation principles.

In order for a human rights officer to be able to assist and advocate for a client, and also to feel comfortable doing this as a staff person within the program/facility, it is quite important

that the human rights officer understand and be able to apply basic principles of negotiation. These principles can allow the human rights officer to do his work effectively with a minimum of confrontation or divisiveness. What follows are the outlines of negotiation principles which are based upon and explained in detail in a book by Roger Fisher and William Ury entitled Getting to Yes.

Negotiation is communication. Negotiation is nothing more, and nothing less, than communication. Communication can occur in countless ways. Even not speaking to someone is a form of communication which carries a particular message.

Understand everyone's interests. It is quite important to identify clearly all of the interests of the relevant parties - for example, the client and the staff involved in the issue. Interests have everything to do with what people are really concerned about and sometimes little to do with what is being said. For example, a client may be seeking an opportunity to go out on a particular outing. Staff have said "no". Is the interest of the client only to join this particular outing or is there a broader interest in joining some outing in the near future or in simply getting outside of the house for a few hours or in doing something with a group of clients and staff? What are the real interests of staff? Are they saying no to the client because they feel he or she cannot responsibly handle this particular outing at this particular time, do they want to penalize the client or are they concerned mostly about liability should something go wrong?

Seek to maximize interests. Once you have identified the real interests at stake, take a creative, problem-solving approach designed to think through all the possible resolutions which can satisfy the actual interests (or at least the most important interests) of everyone concerned. In other words, look for win-win solutions which can allow the client to attain his underlying purposes and at the same time respect the legitimate concerns of staff. For example, in the above "outing" example, perhaps there is a way for the client to join the outing if something else occurs to satisfy the staff. Or perhaps there turns out to be no way for the client to join this particular outing, but the client's interests could be met through some other outing or some other event or arrangement. Sometimes brain-storming sessions can be quite useful for inventing new solutions. Deadlocks often occur when there has not been enough creative thought given to understanding and then finding a way to satisfy everyone's legitimate interests.

Arguing is not negotiating. The goal of negotiation is to persuade the decision-maker, not to beat the other side into submission. Arguing is therefore neither necessary nor useful. Rather, think of your negotiator role as the role of a teacher who seeks calmly to clarify and explain so that the student will become convinced of the merits of your case.

Identify perceptions. When seeking to persuade, it is quite important to understand the other person's perceptions of the issue. Remember that often the other person's perceptions are the problem that needs to be resolved. Understanding these perceptions is critical if one hopes to change them.

Understand emotions. What may be separating the parties may be emotions - perhaps the emotional need to appear in control of clients or staff, or the client's need to feel included, for example. It is important to identify these emotional issues and develop strategies for addressing them as they often play a critical basis for a person's positions.

Use facts and authorities. In order to educate and therefore persuade, it is quite important to use facts and authorities. Authorities include regulations, policy or law, for example, which are generally accepted as objective and binding on the program/facility. Authorities also include experts from within and outside the program/facility - lawyers and clinical experts, for example.

Timing and form of the message. Think about when a message should be communicated, what form the communication should take, and who should communicate it. For example, a planned meeting in a quiet office usually results in communication far different than a hasty discussion in a corridor. The message that a program/facility's practice violates a DMH regulation may have a very different impact depending on whether the messenger is DMH Legal Counsel or a lay person. Similarly, an expression of concern regarding a program/facility practice may be received quite differently depending on whether it comes from the chairman of the human rights committee, a program/facility staff person, one client or a petition signed by all of the program/facility's clients. Remember, negotiation is nothing more and nothing less than communication, so choose the message and how it is delivered with care.

Consider the BATNA. Sometimes it is best not to negotiate any further. One can best determine when this point has been reached by identifying one's BATNA - the Best Alternative to a Negotiated Agreement. If the BATNA is better than what can be achieved through negotiations, it may be time to end the negotiations.

XVI. HUMAN RIGHTS COMMITTEES.

A. In general.

Each program/facility which is operated or funded by the Department must come under the jurisdiction of a Human Rights Committee. This chapter, derived from DMH Policy # 95-4 (pages 10-14, 17-18) and applicable regulations, explains how this is to occur.

1. Vendor- or facility-based Human Rights Committees. The Human Rights Committee serves as an advisory committee to the head of the program/facility in order to help the program/facility protect the human rights of its clients.

A single Human Rights Committee may oversee multiple program sites and/or multiple programs; provided, however, that the number, geographic separateness or programmatic diversity of the programs and sites are not so great as to limit the effectiveness of the HRC. It is expected that there be a separate HRC for each inpatient facility.

The Area Director may require alterations in the structure, composition or other aspects of the HRC in order that the HRC may more effectively protect the rights of clients and comply with DMH Policy # 95-4.[145]

2. Local area-based Human Rights Committees. If an Area chooses to establish local area-based Human Rights Committees rather than to require vendor-based HRCs, then each local geographic area within the Area must establish one or more Human Rights Committees to oversee and monitor the human rights of clients in all of the programs located within that geographic area (referred to as a "CCSS" in the DMH Human Rights Policy # 95-4). Each local HRC is likely to oversee a variety of programs and program sites. But, it is generally expected that there be a separate HRC for each inpatient facility, and a HRC for child/adolescent programs may be organized at the Area, rather than local, level. Once these HRCs have been established within an Area, any additional HRC established by the program/facility will be optional, rather than mandatory, and will not be governed by Policy # 95-4.[146]

The local area-based Human Rights Committees serve as an advisory committee to the local site director and Area Director and to the programs in order to help them protect the human rights of their clients.

3. Discharging a Human Rights Committee member.

No member of a HRC may be disciplined or discharged for appropriately carrying out his/her human rights responsibilities or may in any way be discouraged from appropriately carrying out such human rights responsibilities.[147]

4. Regulatory requirements.

In some instances, requirements contained within DMH policy go beyond the minimal requirements established in the regulations and in other instances clarify requirements in the

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[145]DMH Policy # 95-4, page 10.

[146]DMH Policy # 95-4, pages 17-18.

[147]DMH Policy # 95-4, page 4.

regulations. A HRC must meet the minimal requirements of the applicable regulations, as well as the requirements set forth in this policy.

See 104 CMR 27.14(2) for regulatory requirements regarding appointment, responsibilities, composition and operation of Human Rights Committees in inpatient facilities (and IRTPs) operated by or under contract with the Department; see 104 CMR 28.11 for community programs operated, licensed or under contract with the Department.

B. Appointment of the committee.

1. Vendor- or facility-based Human Rights Committees. Human Rights Committees are originally appointed by the head of the program/facility. When vacancies occur after the initial appointment of the Human Rights Committee, the Committee must prepare a list of candidates for membership, and the head of the program/facility must appoint new members from this list. After reviewing the list, the head of the program/facility may request that the Committee submit a list of one or more additional candidates if necessary so that the Committee will be able to meet its membership requirements and carry out its responsibilities pursuant to this policy.[148]

2. Local site-based human Rights Committees. Local site-based Human Rights Committees are originally appointed by the local site director, with approval by the Area Director for HRCs covering a local site, by the Area Director for an Area-based HRC for children/adolescents, or by the head of an inpatient facility for a separate HRC for an inpatient facility - this person who appoints HRC members is referred to below as the "HRC appointing authority". When vacancies occur after the initial appointment of the Human Rights Committee, the Committee must prepare a list of candidates for membership, and the HRC appointing authority must appoint new members from this list. After reviewing the list, the HRC appointing authority may request that the Committee submit a list of one or more additional candidates if necessary so that the HRC will be able to meet its membership requirements and carry out its responsibilities pursuant to this policy. The HRC appointing authority approves any reappointment of HRC members.[149]

3. Length of term.

Terms of office for Human Rights Committee members must be determined by the Committee but may not exceed three years. Members may be appointed for additional terms, with the consent of the Human Rights Committee and the head of the program/facility. However, no member may serve more than six consecutive years on a Committee. A person who serves six consecutive years may be reappointed to the Committee after a year's absence from the Committee. A member of the Human Rights Committee may be dismissed only upon a two-thirds vote of the Committee.[150]

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[148]DMH Policy # 95-4, page 11.

[149]DMH Policy # 95-4, page 18.

[150]DMH Policy # 95-4, page 11.

C. Membership.

The DMH Human Rights Policy provides that Human Rights Committee must be composed of at least seven members.[151]

At least one member of the Committee must be a client or former client of the kinds of services provided by the program(s) being monitored by the committee, except that if a HRC only oversees program(s) with clients who are all under the age of 16 years, the client representative may be a legal guardian of a client. Reasonable accommodations must be made to client members of the Committee to allow them an equal opportunity to participate on the Committee.

At least one member of the Committee must be a family member of a client. At least one member of the Committee must be a clinician. At least one member of the Committee must be an attorney, paralegal or law student who is or will soon become knowledgeable about the rights of persons with mental illness. An attorney, who represents one or more clients who are served by the program/facility, may be a member of the Human Rights Committee but the attorney may not participate as a Committee member in any discussions or decisions regarding his/her client's rights which are the subject of the attorney's representation.

At least sixty percent of the Committee members must be clients, family members or advocates. An attorney, paralegal or law student is considered an "advocate" for these purposes.

Each member of a Human Rights Committee must be a person who is committed to protecting and promoting the rights of the persons served by the program/facility.

No member of the Committee may have any direct or indirect financial or administrative interest in the Department or in any of the program/facilities under the jurisdiction of the Committee. For purposes of this policy, membership on a DMH citizen advisory board, board of directors of a program/facility or board of trustees of a program/facility does not constitute such a financial or administrative interest; and receiving services from the program/facility or being a family member of a client of the program/facility does not constitute such a financial or administrative interest.

No member of the committee may have any other responsibilities or interests which are inconsistent with his or her commitment to human rights.

The racial and ethnic balance of the Committee should reflect the racial and ethnic population served by the program/facilities which are under the jurisdiction of the Committee.[152]

The Human Rights Officer may not be a member (either voting or non-voting) of the Committee. The Human Rights Officer serves as staff to the Committee.

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[151] DMH Policy # 95-4, pages 11. Note that DMH regulations, which were amended more recently than the Policy, require only a minimum of five persons. However, the DMH Human Rights Policy provides that where the requirements in the Policy go beyond the regulations, a Human Rights Committee must meet the minimal requirements of both the regulations and the policy. DMH Policy # 95-4, pages 10-11.

[152] DMH Policy # 95-4, pages 11-12.

D. Organization and operation of the committee.

The Committee must meet as often as necessary upon call of the chairperson or two of its members. A Committee must meet no less often than quarterly. However, monthly meetings are recommended for all programs and are required if the Committee has responsibility for an inpatient facility. Minutes of all Committee meetings must be kept and a copy filed with the Area's human rights coordinator. Minutes must include a description of human rights concerns discussed by the Committee and how the Committee has resolved or otherwise addressed them.

Each Committee may develop its own operating rules and procedures consistent with this policy. The committee may delegate functions to one or more subcommittees.[153]

Each Committee member should be careful not to participate as a Committee member in discussing or otherwise addressing any issue or other matter regarding which he or she has a direct or indirect financial interest. An attorney or legal advocate who has one or more clients who are served by the program/facility may be a member of the Human Rights Committee, but the attorney should not participate as a Committee member in any discussions or decisions regarding the rights of his or her clients.

E. Liability of Committee members.

Department of Mental Health attorneys have concluded that there exists little, if any, potential for liability of Human Rights Committee members. The attorneys reach this conclusion principally because liability must be based on there being a direct and clear relationship between the harm done and the actions or inactions of the Committee. The responsibilities of the Committee are advisory and do not extend to providing, supervising or controlling services. The DMH attorneys also note that if the Committee is appointed and empowered by a DMH employee, the state Tort Claims Act (MGL c. 258) would likely result in indemnification to Committee members for any actions within the scope of their Committee responsibilities.[154]

F. Responsibilities and authority.

The Human Rights Committee is a volunteer, advisory body which is established to help ensure that program/facilities promote and protect the human rights of all persons whom they serve. The Committee carries out its responsibilities by (i) gaining a thorough knowledge of the program/facilities and the persons served, (ii) working closely with the program/facility directors, staff and Human Rights Officers to identify, monitor and resolve any limitations on human rights and (iii) serving as an advocate for all persons served by the program/facilities.

As an advisory body, the Human Rights Committee does not have responsibility for the operation of the program/facility, nor can it assume a role played by the clinical or administrative staff employed by the program/facility. Its voice, however, can be heard clearly by the program/facility, and it can have a significant impact on the clients' human rights, depending on

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[153]DMH Policy # 95-4, page 12.

[154]Letter of August 2, 1983 from DMH Deputy General Counsel; memo of February 21, 1980 from DMH Legal Counsel.

the knowledge and credibility of its members, negotiation skills, clarity of purpose, persistence and ability to work effectively and constructively within the mental health service system.

Perhaps the most important responsibility of a Human Rights Committee is to keep the program/facility focused on the client. Inevitably and understandably, there are fiscal, administrative and practical constraints on any program/facility, and all program/facility staff must be concerned about these realities. Without denying or ignoring these constraints, the Human Rights Committee can take a more single-minded focus by continually reminding the program/facility of its overriding purpose of serving the needs and desires of each client and respecting his or her human rights.

Specific responsibilities of the Committee are to:

- Make inquiry into complaints and allegations of client mistreatment, harm or violation of a client's rights; file complaints as appropriate; and monitor the process used to investigate and resolve complaints. The inquiry made by a HRC is informal in nature and should not be duplicative of any complaint investigations. (The HRC's role in filing and monitoring complaints is discussed in more detail below in part G.)

- Review and monitor limitations on a client's movement; review and monitor any other potential limitations on human rights, including involuntary medication, restriction of privileges, house/ward rules that limit client rights, limitations on use of a client's funds and other possessions, and behavior modification programs. (The HRC's role in monitoring restraint, seclusion and other forms of room restrictions is discussed in more detail below in part H.)

- Review the reports of the various quality management activities, including the citizen monitoring program, to ensure that human rights issues raised through these mechanisms are addressed.

- Review and monitor the methods used by the program/facility to inform clients and staff of the client's rights, to train clients in the exercise of their rights, to inform legal guardians of their role in protecting client rights, and to provide clients with opportunities to exercise their rights to the fullest extent of their capabilities and interests.

- Review proposed and existing policies and practices which are relevant to client rights; make recommendations to the program/facility to improve the degree to which the rights of clients served by the program/facility are understood and enforced.

- Visit each program/facility site covered by the HRC with prior notice (or without prior notice, provided good cause exists) at least once each year, and those persons visiting the program/facility report their findings to the full HRC.

- Meet regularly with the Human Rights Officers of the programs/facility it oversees to provide guidance, direction and support to the HROs; to receive

reports of the activities of the HROs; and to ensure that the HROs are carrying out their responsibilities.

- Have access to clients, their legal guardians, client records, incident reports, vendor policies and staff in order to carry out the above responsibilities. The program/facility may, but is not required to, remove client-identifying information prior to it being shared with the Committee; provided that the identifying information must be removed if so requested by the client. The Committee must respect the privacy and confidentiality of any information it receives which identifies a particular client.[155]

G. Filing complaints and monitoring the complaint process.

The DMH Investigation Regulations (104 CMR 32) allow any person (and require any staff person) to file a complaint if there is reason to believe (or there is a non-frivolous allegation) that there has occurred or is occurring a dangerous, illegal or "inhumane" condition or incident, or a medicolegal death.[156] State law mandates other reporting to (i) the Disabled Persons Protection Commission as soon as there is reason to believe that serious physical or emotional injury has occurred to an adult as a result of abuse by a caretaker or that a death has occurred,[157] (ii) to the Department of Social Services if there has been abuse or neglect of a child[158] or (iii) to the Department of Elder Affairs if there has been abuse or neglect of a person sixty years or older.[159]

When necessary, in order to have a more formal process (including an investigation into the facts), the Committee may want to file its own complaint (under 104 CMR 32) regarding any dangerous, illegal or inhumane incident or condition. In addition, the Committee may become a party to a complaint filed by another person by filing with the person in charge a notice to intervene.[160] As a party, the Committee will receive copies of all reports, appeals notices and other significant documents relevant to the resolution of the complaint and will be able to appeal any finding or decision on the grounds that there has been a violation of the investigation regulations.

Obtaining a copy of and reviewing each complaint that is filed with respect to the program/facility is an excellent way for the Committee to keep abreast of any concerns of clients, family members and staff. By reviewing the investigations and decisions regarding these complaints, the Committee can also understand how well the complaint process works and how responsive it is to human rights issues. A subcommittee of the full Committee may take responsibility for monitoring this area and regularly reporting to the full Committee, or the Committee may ask for staff assistance from the Human Rights Officer.

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[155]DMH Policy # 95-4, pages 12-13.

[156]See discussion in part IX of this Handbook.

[157]MGL c. 19C, s.10. Program/facility staff are mandatory reporters under this statute.

[158]MGL c. 119, s. 51A. Program/facility staff are mandatory reporters under this statute.

[159]MGL c. 19A, s.15. Program/facility staff are mandatory reporters under this statute.

[160]104 CMR 32.02 (see subsection (g) in the definition of "party")

The Human Rights Committee should consider appointing a subcommittee to monitor complaints and to report on a regular basis to the full Committee. The Committee may also want to ask for staff assistance from the Human Rights Officer.

H. Additional responsibilities regarding restraint and seclusion, and other forms of room restrictions.

DMH Human Rights Policy # 95-4 (page 14) gives the Human Rights Committee responsibility to review and monitor individual incidents of restraint and seclusion (R/S), room restrictions (e.g., "room plans"- the planned restriction of the client to his/her room), as well as general practices and trends by performing the following tasks. A R/S Subcommittee and a HRO may assist the HRC with these tasks. The HRC is to:

- Receive a copy of each R/S form (including the client comment sheet) and room plans.

- Review all R/S forms (and client comment sheets), room plans and other relevant documents as necessary to identify any client concerns and other human rights issues regarding the use of R/S and other kinds of room restrictions.

- Follow through with clients and/or staff to address human rights concerns identified on R/S forms (and client comment sheets), and ensure that 104 CMR 24 complaints are filed as necessary to address any illegal, dangerous or inhumane incident or condition. The RESTRAINT/SECLUSION MONITORING FORM (or a revised version of it) should be used to follow through with staff, and the HRO may be used by the Committee to follow through with clients. (The form is the next page of this handbook.)

- Monitor R/S, room restriction practices, policies and training; monitor any extended use of R/S or other room restrictions for individual clients; monitor circumstances which generally tend to lead to violence or confrontation. Follow through with clinical and/or administrative staff to address any particular concerns.

- Review the program/facility's aggregate quality management data regarding R/S.

- Review recommendations of work groups addressing the program/facility's practices and policies regarding R/S and other room restrictions.

- Make recommendations to the facility regarding ways to reduce R/S and other room restrictions, and to make it more humane.

RESTRAINT/SECLUSION MONITORING FORM
of the Human Rights Committee

This form was sent to: _____ Date: _____
Please review the attached restraint/seclusion form. The Human Rights Committee (HRC) has identified areas of concern (described below). Please return this form to the Human Rights Officer with written response to these concerns, no later than _____ .

HRC member monitoring R/S: _____

Client's initials: _____ Client's #: _____

Date of restraint/seclusion: _____ Time: _____ Ward:_____

Concerns identified by HRC: _____

_____

_____

_____

_____

Staff response to HRC concerns: _____

_____

_____

_____

_____

Date returned to HRC: _____ Date reviewed by HRC: _____

HRC member reviewing: _____

Further follow-up by HRC: _____

_____

_____

XVII. "The Customer is Always Right", by Annette Hanson, M.D. and Bill Crane.[161]

In the world of commercial sales and services, the phrase "the customer is always right" is often accepted as a principle to guide decision-making in order to satisfy the customer and help ensure a profitable and successful business. What is not as widely understood or accepted, is that this phrase works equally well in the world of mental health care.

The mental health "customer", of course, is the client of care and treatment within the system of mental health services. We believe that the mental health "client is always right".

Anyone employed by the Department of Mental Health or by a DMH vendor, whether he or she be a psychiatrist, administrative assistant, mental health worker, program manager, janitor or chief operating officer, has only one justification for working within the mental health system and that justification is the client - ultimately, all of us work for the client. Without the client, we would all be doing something else, and if we fail to appreciate the implications of this principle, perhaps we should be doing something else.

Not only is this true when one looks at the big picture. These principles also need to be reflected in the day-to-day decisions and actions that we take as employees of DMH or its vendors. There can be no justification for developing an individual treatment plan, for example, or deciding when to discharge a client from the hospital, or making a policy decision, or establishing a new program if it is not done to serve the needs of the client and only to serve the needs of the client.

Working for persons with mental illness, we sometimes fall into the role of doing things for the client. Most particularly, we grow accustomed to making decisions for the client - decisions that we feel reflect the best interests of the client. This is often justified by the reality that a psychiatric illness can cloud a person's judgment or can contribute to dependent, antisocial and at times even violent behavior from which society or an individual may need to be protected. But, these manifestations of mental illness should not and need not alter the more fundamental principle that all services of the Department, including all decisions regarding those services, need to be grounded on meeting the client's needs and, most importantly, the best person to tell us what those needs are is the client.

We need to end the practice of infantilizing the client. We too often fall into the trap of assuming that because we are professional clinicians or experienced administrators or devoted family members or simply "well" people, we somehow know better the needs of the clients than the clients know those needs themselves. Those of us who are not clients - no matter how sophisticated, no matter how knowledgeable and no matter how committed to the interests of the client - must continually be careful to bring out, not to drown out, the voice of the most important participant - the client.

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[161] Annette Hanson is the former Deputy Commissioner for Clinical and Professional Services at the Mass. Department of Mental Health. Bill Crane is the Special Assistant for Human Rights at the Mass. Department of Mental Health.

We should, for example, give the individual treatment planning process back to the client. During the treatment planning process, we should be asking the client "What do you want while you are here?" "What are your goals and objectives?" "What do you want to happen when you leave here?" "What services and supports do you need to meet your objectives to live, work and have relationships in the community?" If the client is not at the center of this planning process, what legitimacy can it have? How can it be considered to be planning to meet the needs of the client if we have not honestly tried to find out from the client (indeed, if we have not let the client tell us) what his or her needs are and how they can be met, and make that the center of the planning process? This is not to minimize the critical contribution of clinicians, family members, etc. in the treatment planning process - rather, the point is to emphasize that the planning process should belong to the client.

Sometimes we find it easy to forget that mental health services are not simply a question of keeping someone safe or prescribing the most effective medication to relieve symptoms of a mental illness. Mental health services, more than many other health services, need also to take into consideration other aspects of the person. Often a critical ingredient for someone to become mentally healthy again is first to have meaningful work or meaningful personal relationships, or to live in one's own home, or to have a sense of confidence and self-worth by taking responsibility for one's own decisions - this is what we learn from listening to clients. A mental health system which assumes that all that is necessary is for the patient to be cared for by technicians who are experts at diagnosis, treatment and the control of clients is a mental health system that abuses its clients and is doomed to failure.

A renewed emphasis on putting the client in the center of the service system, indeed an empowering of the client to tell us his or her needs and letting the system then respond to those needs, does not negate or undermine very high quality clinical care. In fact, our definition of high quality clinical care depends on the client and client-choice being at center stage.

Clinicians are obviously an essential ingredient to the professional services provided by a mental health system, and the system must promote and support the highest clinical standards of practice. A system which makes it impossible or even difficult to give high quality clinical care will never serve clients well and is likely to be rife with human rights violations.

But high quality clinical care does not mean dictating to clients what their needs are. It does not mean building more hospitals when the clients are telling us that instead they need more supports to remain in the community. It does not mean contracting for more group residences when the clients are telling us that instead they need to be supported in their own homes. It does not mean developing sheltered workshops when the clients are telling us that what they need are real jobs and the supports to make that a reality. And similarly, it does not mean making paternalistic decisions to avoid day-to-day risks of embarrassment or hardship for a client when the client is able to make these decisions and take on the responsibility for these risks.

It is true, of course, that some clients need to be protected from significant harm or harming others. This is a most serious responsibility of the Department that should not be compromised. But, at the same time, it bears keeping in mind that the client who is likely to seriously harm others or the client who needs protection from harming himself or herself is the exceptional case. And if the client may be placed at risk of harm to self (for example, if given the opportunity to visit a friend or work in the community) but is able to appreciate and take

responsibility for that risk, that client needs to be given back control over these decisions, rather than staff playing the role of protecting the client or deciding themselves what is best.

We need to be willing to allow the client to take some reasonable risks. The more conservative decision is often the one that continues the status quo of care and services in a protected environment, and often separates the client from the everyday world of choices, relationships, work and housing in the community - the only place where we have the opportunity to grow, to have a meaningful life and sometimes to fail. We need to recognize that the client cannot be "cured" if the system too often refuses to allow the client to become integrated back into society and to take back responsibility for his or her life. At the same time, this should never become an excuse to fail to offer services or supports, but rather it becomes a mandate to offer those services and supports which the client has chosen to help reach his or her own goals.

When we put the client back into the center of the mental health system, the services and the system become the client's, and the rest of us work for the client rather than for an anonymous system. The treatment record and the treatment plan become the client's record and the client's plan, not the hospital's record or the treatment team's plan, and the client is invited to have access to both documents. In adopting a house rule, a community residential program thinks of the rule as belonging to the residents and to be adopted by the residents after discussing it among themselves. The entire system works towards supporting and encouraging clients to make choices and respecting those choices rather than adopting institutional or program rules which sometimes serve only the needs of staff. And finally, the mental health system is judged on the basis of objective standards which reflect how successfully we have met the needs articulated by the client.

Putting the client into the center of the mental health service system will not happen by itself. It will take hard work and a conscious effort to change the way we have been thinking and making decisions and relating to the client. A total quality management system recognizes not only the importance of client input, but also the need to carefully structure opportunities for meaningful client participation and feedback. Client advisory committees, client forums, user-friendly comment forms, the DMH Office of Client and Ex-patient Relations and client satisfaction surveys are some important ingredients.

And in the end, is the client always right? Of course, no one is "right" all of the time. None of us is wise or competent or compassionate about every matter that comes up in our lives for decision or action. But when we develop an expensive and elaborate service system to help mental health clients, we need to recognize that the system itself exists only to serve the client. Our responsibility is to use our energies and skills to honor the client's expression of need and from this point of view, the client in fact is always right.

XVIII. TRAINING STANDARDS FOR HUMAN RIGHTS.

DMH Human Rights Policy # 95-4 (pages 14-15) requires that all staff who have responsibility for the clinical care or treatment of clients receive training regarding human rights and responsibilities during orientation and annually thereafter, as provided in the program's training plan (see subpart XIVA4 above). The orientation training must include a comprehensive explanation of the topics described below, and the annual training thereafter must include a review of these topics.

Human rights topics to be addressed in orientation and in-service training include:

- All applicable complaint procedures, including when a complaint must be filed, how to file a complaint, who must file a complaint, the right of a client, guardian or other person to file a complaint, the process that is used for investigation and/or resolution of the complaint (see chapter IX of this Handbook).

- The role and responsibilities of the Human Rights Officer and Human Rights Committee (see chapters XV and XVI of this Handbook).

- The value of human rights and responsibilities - i.e., why it is important that each staff fully respects the human rights and responsibilities of each client (see chapters I, II and III of this Handbook).

- The rights and responsibilities of clients (and the role of legal guardians in protecting the rights of children, adolescents and others under guardianship) as described in DMH statutes, regulations and policies. (See chapters IV, V, VI, VII, X and XI of this Handbook.)

The training exercises in chapter XIX of this Handbook may prove useful to human rights trainers.

XIX. TRAINING EXERCISES.

DIGNITY AND RESPECT: TRAINING EXERCISES.

A. Hypothetical.

Ms. X lives in a community residence. Any time she needs spending money for her daily needs, she must ask a staff person for the money because staff feel she spends her money on frivolous items and sometimes she loses her money.

Mr. Y is an inpatient in a state hospital. He has strong but sometimes unrealistic ideas about what his treatment should be. He is not being invited to his treatment team meetings.

At the most recent team meeting, the team decided that on the basis of the physician's recommendation, Mr. Z should not be allowed to smoke because smoking appears to be aggravating his asthma condition. Mr. Z understands the risks from smoking. Staff have informed Mr. Z that he may not smoke.

Ms. T is receiving outpatient therapy and antipsychotic medications. Her psychiatrist has told her that it would be best for her to change medications. The psychiatrist has told her that when she is feeling better and he has more time, he will explain to her the possible side effects, but in the meantime she should take the new medication.

A, B and C live in a supervised apartment (or inpatient ward). The director of the apartment (or unit director) has recently established a rule that no snacks or smoking will be allowed after 9:00 PM - no exceptions. When asked by ABC why she established this new rule, the director stated that it would promote a healthier and cleaner environment and that some clients had abused their snacking and smoking privileges.

B. Questions for discussion.

In one or more of the above hypothetical, what assumptions are being made by staff about the clients, the clients' needs and desires and their ability or appropriateness to understand and act on their own needs and desires?

What are the likely reactions of the client(s) to the decisions by staff and to the process used by staff to reach these decisions?

Try to imagine yourself in this situation. How would you react? How would you want to be treated or cared for?

PARTICIPATION IN TREATMENT PLANNING: TRAINING EXERCISES.

A. Hypothetical.

Ms. X is perceived by staff as angry and often irrational. Her father is her guardian. The social worker denied her request to participate in the next treatment team meeting, knowing that the treatment team members did not feel they had the time to meet individually with each client.

that Ms. X would be angry and perhaps irrational during such a meeting and that her participation would serve no purpose since the treatment team had already decided on the plan and the plan had been agreed to by the guardian.

B. Questions for discussion.

Does the client always have the right to participate in treatment team meetings?

What if the client has a guardian? What if she does not have a guardian but cannot effectively or fully participate in the discussion of her treatment plan?

What purpose, if any, does it serve to invite the client to participate in treatment planning if the client is irrational or angry, or has a guardian who has the authority to agree or disagree to the treatment plan?

What is the likely result of not inviting the client to participate in the treatment planning meeting?

CONSENT TO TREATMENT: TRAINING EXERCISES.

A. Hypothetical.

Mr. X was recently admitted to a hospital. At the time of admission, he was highly agitated and unable to understand where he was or how he got there. The attending psychiatrist told Mr. X that he was prescribing a particular antipsychotic medication for him that would be administered by a nurse. Mr. X did not respond. He later passively accepted the medication by mouth.

Ms. Y is under a general guardianship. The guardian has given consent to staff to administer a particular antipsychotic medication. Staff are not sure whether the guardian has the authority to consent.

Ms. Z resides in a community program. She has been advised by staff that if she did not take her medications, she would not be allowed to continue living at the program. Believing she has no choice, she has accepted the medication.

One month later, Ms. Z has developed hair growth on her face and other side effects. She has not been informed about these potential side effects although she signed a statement which states that she agrees to take the medication and understands that there may be negative side effects.

B. Questions for discussion.

When can a client be given medication without his or her consent?
To what extent does a client have to be informed of possible side effects?
Who, other than the client, can consent to or refuse treatment?
What is the role of the guardian in treatment decisions?

INPATIENT/PROGRAM RULES: TRAINING EXERCISES.

A. Hypothetical.

Mr. X has a copy of the book Final Exit, which describes how one can kill himself. The treatment team has decided that it might be dangerous for the book to be accessible to any clients in the program/facility and have decided to ban the book. Staff have confiscated the book and have destroyed it.

Ms. Y wants to have a visit from her partner. The treatment team feels that the relationship between Ms. Y and her partner may be interfering with the treatment plan and may result in sexual activity.

There is also a rule against former clients visiting within six months of terminating services, and Ms. Y's partner was a client at the facility/program up until a month ago. For all of these reasons, staff have barred visitation by Ms. Y's partner.

Mr. Z has made a threatening phone call to his wife. Mr. Z's wife calls the facility/program and asks that he not be allowed to call her.

The guardian of a client has asked that the client have no visits from the client's former spouse.

The ABCD community residence has decided to ban all smoking within the residence. Three clients in the residence smoke. During a house meeting, they have asked the residence director to reconsider this rule.

B. Questions for discussion.

When can a client be restricted with respect to possessions, visitation, telephone access and mail? Can the guardian require staff to restrict these rights?

What can a client do if he disagrees with the restriction?

When can house (or ward) rules restrict clients generally?

Does the house (or ward) have to consult the clients before deciding upon a house (or ward) rule? Should it consult the clients if there is no obligation to do so?

CLIENTS' FUNDS: TRAINING EXERCISES.

A. Hypothetical.

Mr. X has brought back $100 with him from a recent visit with his parents. Staff have asked that he give the money to them for safekeeping, but he has refused.

Ms. Y has $1,000 which is being held by the program/facility. Each week staff give her $5 for spending money. She has asked that this be increased to $10 so that she can buy more

cigarettes for herself and her friends. Staff do not want to promote smoking and have denied the request.

Mr. Z has offered to pay a staff member $100 to accompany him on a weekend trip to New Hampshire.

B. Questions for discussion.

When can staff take funds from a client?

When should staff give funds to a client?

What can a client's funds be used for?

When should staff assist a client to understand better how to use and manage his funds?

When should staff seek the appointment of a guardian, conservator or representative payee?

HUMAN RIGHTS COMPLAINTS, INVESTIGATIONS AND REPORTING OF ABUSE: TRAINING EXERCISES.

A. Hypothetical.

Mr. X has left his personal area a mess, with dirty laundry strewn on the floor. When the staff member came upon this, she started yelling at Mr. X, calling him a slob.

Ms. Y is on 1-1 observation. The male staff person, who was specialing her, followed her into the bathroom because no female staff were available.

Mr. Z became assaultive. Fearing that she was about to harmed by the client, the staff member hit the client with a chair.

Ms. T spit at a staff person and started swearing at him. She was put into physical restraint. She wants to file a complaint against staff.

B. Questions for discussion.

What is considered abusive or inhumane treatment?

When are staff required to file a complaint?

What recourse does a client have if she believes her human rights were violated?

CONFIDENTIALITY, PRIVACY AND RELEASE OF RECORDS: TRAINING EXERCISES.

A. Hypothetical.

Ms. X has asked to see her records. Staff believe that it would upset Ms. X if she were to see her records.

An employee is appealing (through arbitration) a disciplinary action and would like to have Mr. Y's records disclosed to the arbitrator.

Ms. Z was given a chemical restraint in view of other male and female clients.

Clients A, B and C would like to spend some time together in private. Staff are concerned that clients A and B may take advantage of client C.

B. Questions for discussion.

When can a client see her own records?

When can others see a client's records?

What right of privacy do clients have?

RESTRAINT AND SECLUSION: TRAINING EXERCISES.

A. Hypothetical.

Ms. X is resting in bed. The program director (or charge nurse) has asked that all clients be out of bed at this time. Two staff go to Ms. X and tell her to get out of bed. Ms. X refuses, saying that she will hit anyone who tries to get her out of bed. The staff gently take hold of her to ease her out of bed. Ms. X hits staff, who then pull her out of bed and put her into restraint.

Mr. Y is getting agitated and talking in a loud, threatening voice. He is a large person who has a criminal history of assault and battery. A female staff person who knows Mr. Y and has a trusting relationship with him quickly begins to speak quietly with him and walks beside him as he paces through the corridor. Mr. Y appears to feel more secure, less afraid, while speaking with the staff person. The staff person asks other staff to stay away, knowing that Mr. Y may well escalate if confronted by a show of force. After a half hour, Mr. Y has calmed down and no restraint or other restriction is used.

Ms. Z is getting agitated and is talking in a loud, threatening voice. She takes a paper cup of water and throws it at the wall, and then goes to her room, shutting the door behind her. Staff follow her, telling her that she must come out and clean up the mess. She tells them to go away, that she needs some space. Staff go into the room, Ms. Z pushes them away, and staff put her into restraint.

Mr. T, for no apparent reason, hits his psychiatrist hard on the back of the head and then sits down quietly. Mr. T is put into restraints for three hours, during which time Mr. T is very calm and in control.

B. Questions for discussion.

When can/should staff put a client into restraint or seclusion?

How can the use of restraint/seclusion be minimized through trusting relationships that give a client a sense of security?

Once put into restraint, when must a client be released?

What are the rights of clients while in restraint/seclusion?

RESOURCES

Department of Mental Health.

Central Office: Special Assistant for Human Rights (617) 727-5500 ext. 420

Office of Client and Ex-patient Relations (617) 727-5500 ext. 405

Area Offices: each DMH Area Office has an Area Human Rights Coordinator

Disability advocacy agencies.

Center for Public Representation (CPR)
22 Green Street
Northampton, MA 01060
tel. (413) 584-1644 x265

and

246 Walnut Street
Newton, MA 02160
tel. (617) 965-0776

CPR specializes in the legal rights of persons with mental illness and discrimination.

Mental Health Legal Advisors Committee (MHLAC)
294 Washington Street, Suite 320
Boston, MA 02108
tel. (617) 338-2345
1-800-342-9092
MHLAC specializes in the legal rights of persons with mental illness.

Disability Law Center (DLC)
11 Beacon Street, Suite 925
Boston, MA 02108
tel. (617) 723-8455 or (800) 872-9992 voice and TTY
DLC specializes in the right of mentally and physically disabled persons to be free from discrimination, the special education rights of persons under the age of 22 years, and the legal rights of developmentally disabled persons.

Legal services programs.

Local legal services programs provide free legal assistance to indigent persons in regard to housing, Social Security Disability and SSI issues, other welfare benefits and (in some instances) domestic relations matters and mental health issues. To locate the legal services office nearest you, call the Legal Advocacy and Resource Center at (617) 742-9179.

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